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1. Curriculum vitae, Awards, Chronological List of papers read and/or published New York June 1975 multigr 6p
2. Stevens, Anita, and Wehrheim, Hans K. "Psychiatry and Juvenile Delinquency" reprint from Behavioral Neuropsychiatry July 1969 7p
3. Stevens, Anita, and Wehrheim, Hans K. "Psychiatric Causes of Learning Disability" reprint from Behavioral Neuropsychiatry April/May 1970 2p

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2.Karte Stevens, Anita AR-A.1328

4. Stevens, Anita, and Wehrheim, Hans K. 4309
"Psychiatric Problems in Evaluating Fitness for Military Service" reprint from Behavioral Neuropsychiatry Oct/Nov.1970 7p

5. Stevens, Anita "Psychiatric Rejects from Military Service and Their Employability in Civilian Life" reprint from Industrial Medicine Vol.39 No.12 Dec. 1970 7p

6. Stevens, Anita "The Role of Psychotherapy in Psychomatic Disorders" reprint from Behavioral Neuropsychiatry Oct/Nov.1972 4p

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7. Stevens, Anita "Emotional Conflicts and Physical Illness: The Psychiatrist's Role" lecture Gracie Square Hospital June 5, 1974 multigr 20p 4309

8. Stevens, Anita, and Harper, John Sanford "Frontiers of Medicine" Columbia Features 1975 multigr 4p

9. Letter Stevens, Anita, Stevens Psychiatric Center New York n.d. to Martin J. Cohen, American Home Products Corporation in New York multigr 2p

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June 1975

CURRICULUM VITAE OF DR. STEVENS

STEVENS, Anita, M.D. Psychiatrist and Psychoanalyst;
Member of the American Psychiatric Association;
Certified in Psychoanalysis by New York Medical College;
President and Director Stevens Psychiatric Center, P.C.,
President and Medical Director Community Psychiatric
Services Foundation, Inc.
Visiting Professor of Psychiatry and Psychoanalysis, University of Guadalajara, Mexico;
Attending Psychiatrist, Gracie Square Hospital, New York City;
Consultant Psychiatrist, Doctors Hospital, New York City;
Consultant Psychiatrist, General Motors Corporation;
Former Medical Advisor in Psychiatry to the New York City
Selective Service System;
Consultant to National Aeronautics and Space Administration;
Consultant to Postgraduate Center for Mental Health;
Formerly President of Section on Psychiatry, Pan American
Medical Association;
Formerly Director of Psychiatry, National Society for
Prevention of Juvenile Delinquency;
Special Consultant to New York State Joint Legislative
Committee on Mental Retardation;
Fellow of American Society of Psychoanalytic Physicians;
Fellow of the American Academy of Psychoanalysis;
Fellow of American Society for Adolescent Psychiatry;

Member of the Board of Medical Examiners of New Mexico;
Founding Member and Fellow of International Congress of Psychosomatic Medicine;
Member of New York Society for Clinical Psychiatry;
Member of American Group Psychotherapy Association;
Member of Eastern Group Psychotherapy Society;
Member of Association for Advancement of Psychoanalysis;
Member of Gerontological Society;
Member of Group for Geriatric Psychiatry;
Member of Psychiatric Society of New York Medical College;
Member of American Medical Women's Association, American Medical Association, New York State Medical Society, New York County Medical Society;
Alumna of Bellevue Psychiatric Hospital of New York City;
Member of Advisory Board of Adams School for Children with Learning Disabilities;
Member of Narcotics Guidance Council of Putnam Valley, New York;
Honorary Member of Quito Psychiatric Society of Ecuador;
Honorary Member of Guayaquil Psychiatric Association of Ecuador;
Honorary Member of Argentine Society of Psychiatry and Psychology in Infants and Adolescents (SAPPIA);
Editor for Adolescent Psychiatry in Journal of Behavioral Neuropsychiatry;

CURRICULUM VITAE OF DR. ANITA STEVENS January 1975

Editor of the Journal of Argentine Society of Psychiatry and Psychology in Infants and Adolescents (SAPPIA); Graduate, University of Bonn; postgraduate studies, University of Geneva, Columbia-Presbyterian College of Physicians and Surgeons, New York University-Bellevue Medical Center, New York Medical College.

AWARDS - William Randolph Hearst Foundation Award for work on emotional problems of adolescents, 1965.

Meritorious Achievement Award from the National Society for the Prevention of Juvenile Delinquency, 1966.

She was given a scroll by the New York City Director of the Selective Service System and the Chief of the Medical Division:

"...in testimony of your willing, able and humane leadership and guidance which have been of inestimable value in the administration of the New York City Selective Service System..."

This was presented October 16, 1969, at the Seventh Regiment Armory, New York, New York.

Woman of the Year in Community Mental Health Field Award from the United Catholic Parents Association of Greater New York May 26, 1975.

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CHRONOLOGICAL LIST OF PAPERS READ AND/OR PUBLISHED

1. "Eclectic Psychotherapy, Pharmacology and ECT in an Acutely Psychotic Patient" - Read at 38th Anniversary Congress of Pan American Medical Association in Caracas, Venezuela, March, 1963. Published in 1963 PAMA Yearbook and Program.

2. "The Role of Psychotherapy in Alcoholism."

3. "Depression and Its Treatment" - Read at 39th Anniversary Congress of Pan American Medical Association aboard S.S. Independence in February/March, 1964.
Published in 1964 PAMA Yearbook and Program.

4. "The Role of Psychiatry in Juvenile Delinquency" - Read at 40th Anniversary PAMA Congress in Miami Beach, Florida, April, 1965.
Published in 1965 PAMA Yearbook and Program.

5. "Anxiety and Reactive Depression" - Read at 42nd Anniversary PAMA Congress in Buenos Aires, Argentina, November, 1967.
Published in 1967 PAMA Yearbook and Program.

6. "Short-term Psychotherapy" - Read at Regional Congress of PAMA in Guayaquil, Ecuador, September, 1968.

7. "Psychiatry and Juvenile Delinquency, Causative Factors and Treatment" - Published in Journal of Behavioral Neuropsychiatry, July, 1969.

8. "Psychiatric Causes of Learning Disability" - Published in Journal of Behavioral Neuropsychiatry, April, 1970.

9. "Psychiatric Problems in Evaluating Fitness for Military Service" - Published in Journal of Neuropsychiatry, October, 1970.

10. "Psychiatric Rejects from Military Service and Their Employability in Civilian Life" - Published in Journal of Industrial Medicine and Surgery, December, 1970.

11. "The role of Psychotherapy in Psychosomatic Disorders" - Published in Journal of Behavioral Neuropsychiatry, October-November, 1972.

ANITA STEVENS, M.D.

PAPERS READ AND/OR PUBLISHED

12. "Validity of Psychoanalytic Principles in Today's Psychotherapy" - read at Annual Meeting of American Society of Psychoanalytic Physicians, Hotel Roosevelt, New York City, April 15, 1973.

13. "Evaluation of LaVerne Rapid Coma Carbon Dioxide Therapy" - Read at CDT Symposium on Addictions, Suffolk Academy of Medicine, Syosset, N.Y.; April 8, 1973.

14. "Report on Carbon Dioxide Therapy for Drug and Alcohol Addiction" - Read at XII Asamblea Médica de Occidente, University of Guadalajara, Mexico, October 30, 1973.

15. "Psychiatric Help for Learning-Disabled Adolescents" - Read at 11th Anniversary Professional Conference 1973, The Adams School, New York, N.Y.

16. Book: "I Hate My Parents!" with Lucy Freeman, published by Cowles Book Co., Inc., New York, 1970.

17. Book: "Your Mind Can Cure," with Lucy Freeman published by Hawthorn Books, Inc., New York, 1973.

18. Book (in progress): "Libido: Life, Lust and Love," with John Sanford Harper.

19. Book (in progress): "Anxiety and Depression," with John Sanford Harper.

20. "Emotional Conflicts and Physical Illness: The Psychiatrist's Role." Speech given at the Meeting of the Active Staff of Gracie Square Hospital, New York, New York, June 5, 1974.

Reprinted from BEHAVIORAL NEUROPSYCHIATRY, July 1969

PSYCHIATRY AND JUVENILE DELINQUENCY

Causative Factors and Treatment

Anita Stevens, M.D.[1] and Hans K. Wehrheim, M.D.[2]

ABSTRACT

In this paper, the most common etiologic factors leading to juvenile delinquency are discussed. The most important ones are biologic in nature and lead to delinquent behavior in interaction with identifiable environmental factors. They include: heightened instinctual aggressivity at puberty, particularly in males; low frustration tolerance and impulsivity; the hyperactive behavior syndrome; specific intellectual dysfunction, such as the reading disabilities; and low intelligence. Also discussed are delinquency in children with high intelligence, and defects in mothering and fathering leading to delinquent behavior. Recommendations are made for prevention and treatment.

Juvenile delinquency is a descriptive term for socially unacceptable behavior in the school-age child —often used for the age groups from 8 to 18 years. Such socially unacceptable behavior in juveniles is as old as human history and has been present in all societies. Specific cultural factors in any one given society can therefore not be the sole cause of it, and biological factors are likely to play an important role.

What are the causes of socially unacceptable behavior in juveniles? The behavior of any organism is directed toward fulfillment of certain needs of the organism. Socially unacceptable behavior is disadvantageous to the average person and the average person is therefore not delinquent. Yet in other people the disadvantages of socially unacceptable behavior may be more tolerable than conforming—which is then more difficult or may even be impossible.

To understand the causes of juvenile delinquency one has to have a precise concept of the structure and function of the human psyche, the forces motivating it, and the needs to be fulfilled. The psychological process takes place in the Central Nervous System, which interacts closely with the rest of the body. All psychological processes can be artificially and descriptively subdivided into the following parts: (1) The Instinctual functions and (2) The Ego functions.

I. Instincts are inborn nervous mechanisms which influence mental behavior. The most important instincts are:

A. The nutritive instincts (hunger and thirst)
B. The sexual instinct
C. The aggressive instinct

For instinctual forces to become acting a "priming" of the instinct has to take place. This priming is accomplished by "priming impulses." For example, a priming impulse for the hunger instinct is a lowering of the blood sugar. When the blood sugar is low, the hunger instinct will cause a conscious perception of hunger, thereby instigating a desire to eat, searching for food and eventually eating. The male sex hormones (androgens) and the specific primers of the sexual instinct, and their sharp increase at puberty leads to a rise in sexual desire and also aggression, a

Read at the American Society of Psychoanalytic Physicians' Meeting held at the New York Academy of Medicine, 2 East 103rd Street, New York City, January 18, 1966.

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[2] Senior Staff Psychiatrist, Oracle Square Hospital; Adjunct Professor of Psychiatry, New York Polyclinic Medical School and Hospital.

need to assert oneself over others. The sharp increase in sexual desire at the ages of puberty is generally known to be a direct result of the increase of the male hormones—the increase of aggressive tendencies is often attributed to psychological rather than biological forces. One often fails to realize that aggression is instinctive—inborn, characteristic of the organism—not exclusively, or even mostly, based on environmental conditioning. It should be obvious that, for example, the aggression of a tiger as compared with a cow is different for constitutional reasons rather than a different upbringing. We are also generally aware of the usual aggressiveness of the mature male animals, particularly in plant eaters, over the immature male or the female animal. In husbandry, this knowledge has been utilized in castration of the maturing male animal to make him more compliant and less aggressive, such as in stallions, bulls, etc.

In human beings, we see with the onset of puberty a sharp increase in sexual desire and aggressive tendencies, particularly in the male. And the incidence of juvenile delinquency is considerably higher in males than in females.

II. The Ego functions comprise all conscious mental activity such as sensory perception (vision, hearing, touch, smell, taste, and proprioception), voluntary motor activity, memorization, and higher mental activity. The ego functions are present in only a rudimentary form at birth and develop as the child grows older. For their normal development two things are required: (1) an intact, healthy central nervous system and (2) proper stimulation and conditioning from the environment.

The Ego functions have also been called the Self, our own self. The ego or self, that is, a person, has the following needs:

A. A need for approval, approval leading to *self-esteem*

B. A need for companionship, or *avoidance of loneliness*

C. A sense of *security* in human relationships as well as financially

In addition, the ego will have to act upon the demands from the instincts, the environment, and conscience.

The conscience (or superego) develops within the ego, actually is a part of the ego. It is formed by training, mostly parental, but also from school teachers, religious instruction, and association with other significant adults as well as contemporaries. It begins as an identification of the child with the set of values the parents have and teach the child. How well a child accepts these teachings does not depend upon the training methods used by the parents but depends also on the "temperament" of the child. As any parent who has several children knows, children are different, some more pliable, others, again very headstrong. These differences are largely biological in nature and depend very little on environmental influences although they may be modified by them.

The ego as stated above, has to mediate between demands from three masters, namely, the instincts, the environment, and the conscience. It will hardly ever be able to fulfill all the demands made, and some will have to be renounced and compromises made. The effect associated with this is called "frustration." The ways in which the ego compromises and adjusts for various contradicting demands made by the three masters are called mechanisms of adjustment or defense mechanisms.

Of great importance for the functioning of the ego, that is, the person, is his ability to tolerate frustration. A lowered frustration tolerance is a common cause of disordered and delinquent behavior. A low frustration tolerance we find in the constitutionally over-reactive and overactive child, in the brain damaged child, as well as in the neurotic and psychotic child.

If we look at the development of the child, we see that the principal developmental task of the first six weeks consists of the stabilization of vital functions, such as sleeping and eating. During the next few months, motor functions become increasingly developed. At 4–5 months, a normal child will begin to sit up and by 9–14 months, it will be able to stand up and walk. More of the ego functions then develop and we see the beginning of the conscience. Developmental disturbances are overactivity, over-reactivity, temper tantrums, crying, and sleep disturbances. Such children have often been called "colicky babies." At four or five years, a child may enter kindergarten and then will have to follow a certain routine and play with other children. Disturbances here again are: overactivity, over-reactivity, low frustration tolerance, inability to take naps, and fighting with other children.

At six years, the child will enter elementary school and for the first time in his life will have to work. To fulfill his required tasks in elementary school, a

child will have to be able to:

I. Sit quietly for a specified length of time and be able to concentrate.
II. Be free from any specific impairment of intellectual functions such as reading disability, spelling disability, dysgraphia, etc., various degrees of aphasia
III. Be of sufficiently high intelligence.

Any interference in the above requirements may lead to aberrant behavior, and as we are now dealing with a school-age child, we will call it juvenile delinquency.

I. Interference with the first of these factors is caused by hyperactivity. This may be due to the child's constitution, and either be inherited or due to brain damage. Hyperactivity, as a symptom, becomes troublesome usually early in school. In parochial schools, where the movement of children is already restricted in the first grade, it causes trouble usually in the first grade. In public schools, the children are generally only required to remain in their seats in the second grade, and the disturbance therefore causes difficulty somewhat later. Under the "instinctual pressure" to move and for "environmental" pressure to sit quietly—and let it be understood that almost every young child has an inherent desire to please authority—the child will attempt to compromise and find excuses for his mobility. The following characteristic behavior is then observed: the child will wiggle in his seat, talk to his neighbors, drop things on the floor and pick them up, break pencil points and get up to sharpen his pencil, find any excuse to get up and walk to the blackboard, or walk to the teacher and ask questions (as there are no specific questions to ask, they will often be irrelevant), go to the bathroom at short intervals, and, if all these resources have been used, just get up from his seat and walk around in the classroom. This behavior is disruptive and the teacher will reprimand the child. The child will soon develop the idea that he is "bad."

To illustrate this point, let me give you the following conversation with a 9-year-old hyperactive boy referred for psychiatric evaluation and treatment because of disruptive behavior.

Physician: "Why were you asked to come here?"
Child: "Because I am bad."
Physician: "Do you want to be bad?"
Child: "No, I want to be good."
Physician: "What would you have to do to be good?"
Child: "Sit quietly, and pay attention to the teacher."
Physician: "You know what to do to be good, then why aren't you?"
Child: "I don't know . . . I can't help it."

This child still had the desire to be good—the frustration had not lasted too long. If children feel sufficiently strongly and sufficiently long that they cannot be good, they may develop the determination to be bad—and then turn into delinquents.

Shakespeare expressed this mental mechanism aptly in Richard III, Act I, Scene I. ". . . since I cannot prove a lover, I am determined to prove a villain."

The child was absolutely correct, he could not help it. He was placed on medication which controlled the hyperactivity, and within two weeks, he was the teacher's pet—now being able to be good.

Example of Constitutional Hyperactivity

A 7-year-old boy was referred because of restless and exuberant behavior in school which had become disruptive. On examination the child was not psychotic nor neurotic, and no neurophysical defects were found. He was of superior intelligence, friendly, charming, but very restless and overactive. The diagnosis of constitutional overactivity was made and pharmacotherapy was instituted to which he responded very well. The mother commented, "It is now a pleasure to have him around." Before treatment he was just a bundle of energy, bursting out all over." When questioned if anyone in the family had shown similar behavioral tendencies, she said, "Yes. I was very much like him. My nickname as a child was Lightning." She had become a dancing instructor, and had found an acceptable outlet for her own motility needs.

Example of Emotional Over-reactivity associated with hyperactivity.

A 9-year-old boy was referred because he had hit a child who had recently undergone cardiac surgery, over the chest with a metal pipe. This boy had shown seriously disruptive and aggressive behavior prior to this incident. He was raised by an aunt who was one year older than his mother, and who lived in the same building with her 2-year younger sister and her family. She related that this boy had serious

difficulty falling asleep and that whenever she entered his bedroom he seemed to be awake. He would also get up at 4 or 5 in the morning and wake up other people in the house. In school he created a continuous disturbance and was constantly involved in fights with other children. He seemed to lose his temper very readily and just recently, had beat up his best friend on a minor provocation.

When questioned as to the boy's mother, she related that his mother had behaved very similarly to him. She had also been unable to sleep, disturbed her sisters early in the morning, had been continuously in difficulties in school, eventually began to take narcotics, became involved in prostitution, once was in a mental hospital, and also in jail. The boy had never known his mother, his aunt had raised him since infancy.

When questioned about her own parents, the aunt related that she could not remember her father who left her family when she was two years old. Only recently had she learned that he had died in prison.

The diagnosis of constitutional overactivity and over-reactivity was made and the boy was placed on tranquilizing medication. Rather large doses were required but then he was able to sleep normally and his aggressive behavior subsided. In this particular case, the behavioral disturbance could not have been transmitted from grandfather to daughter and the son by example.

II. Specific intellectual impairments. Among the specific impairments of intellectual functions without general intellectual retardation we find the reading disabilities which may be due to a dyslexic syndrome (visual agnosia) or a strephosymbolic disorder, auditory agnosic conditions, acalculia, general coordination deficits with poor handwriting, etc. It would go far beyond the scope of this presentation to consider all of them and we shall only discuss the most common one, the specific reading disability, an inability or impairment of reading unrelated to the overall intelligence. This disorder occurs about four times more frequently in boys than in girls and in its minor form, in about five to ten per cent of any given population. Children who are unable to read will experience severe frustration from school failure around the fourth grade when the ability to read is required to do their work—not just in reading but in all subjects. Just as the child with the hyperactive behavior syndrome will consider himself "bad," so the child with a reading disability will consider himself "dumb." He experiences frustration every hour in school and every time he is attempting to do his homework he develops a total sense of worthlessness, particularly if the disorder is not recognized as such, and by continuously criticizing the child, calling him lazy, etc., insult is added to injury. Depending on the temperamental predisposition of the child, he may become shy, withdrawn, and depressed, he may become disruptive, destructive, a class clown, and either way, he may develop a school phobia. The resulting truancy is often the first delinquent act a child commits.

In 1934, the Gluecks (*1*) reported in their study of 1000 delinquent boys of the Boston Juvenile Court that 64 per cent had been truant. The average onset of delinquent behavior was that of the fourth grade in school. Roman (*2*) found that 84 per cent of the cases carried by the Manhattan Children's Court Treatment Clinic showed reading retardation. Balow (*3*) reported that 80 per cent of the Red Wing Minnesota State Training School for Boys were suffering from a reading disability.

III. Low intelligence. Children with low intelligence (I.Q.s below 90)—these are 25 per cent of all children—begin to experience school failure frequently in the fifth to eighth grades and such failure will increase as the child advances in school. Only a few per cent are sufficiently retarded to be placed in special classes for the mentally retarded. The vast majority has to compete with their brighter classmates in a normal classroom situation. In all areas of the school curriculum he will find it very difficult, if not impossible, to succeed. The resulting frustration again will be handled depending upon the temperamental predisposition and underlying personality structure of the child and only too often lead to delinquency, or neurotic and even psychotic manifestations. As intelligence is largely inherited, children with low intelligence usually come from parents with low intelligence; and as in our society low intelligence generally spells low income, such parents are in no position to help their children financially. They then grow up in poverty, surrounded by plenty. Stealing comes rather natural under such circumstances, particularly if no opportunity exists to obtain the desired goods or money in a socially accepted, that is, honest way.

The most common reason for school dropout is academic failure (*1*). Only about 60 per cent of the children who reach the fifth grade go on to graduate from high school—40 per cent drop out (*5*). Our society has made no provisions for 40 per cent—maybe

the Job Corps will be a beginning. The youngsters are completely untrained for any vocation, largely unskilled in reading and writing, have already acquired personality disorders, and no jobs are available. Often, they just hang around street corners and develop a bitterness towards society and disrespect for the law. Frustration and bitterness mixed well with idleness is a perfect recipe for juvenile delinquency.

But what causes behavior disturbances in children who do not suffer from the above-discussed handicaps, who have normal and even superior intelligence, and come from good homes? We shall here discuss two important problems.

First, it is the adolescent of superior intelligence who becomes a rebel against society, who looks down with contempt at society which he considers hypocritical, dishonest, and which, therefore, deserves to be destroyed—or at least altered. He may not be so wrong here—most people are dissatisfied with society, and our governmental institutions and legislative bodies are involved in a continuous struggle to improve society. But the adolescent is typically idealistic and impatient. His ideals are frequently unrealistic, and he may desire a solution which if implemented would be very harmful to society and himself. He comes to such unrealistic and false conclusions, not because of a lack of intelligence or illogical thinking, but because of insufficient premises upon which to draw conclusions. After all, he has had only a few years to gather factual knowledge and even though we may be impressed with a detailed knowledge he may have of specific topics, we are equally impressed by the total lack of knowledge he displays in other areas and which we would certainly expect the average adult to have. And he may also begin to ask philosophical questions, such as, why he exists, what his purpose is, questions which cannot be answered by the average adult, but which the adult has learned not to ask and to be concerned with, or which he answers vaguely but satisfactorily, if only to himself, according to the religion he happens to have. Such existential philosophical dilemma may have a considerably disorganizing influence upon the personality of the adolescent and lead to unacceptable behavior.

The second problem is the isolation of the adolescent from the adult world. The adolescent who needs close adult contacts and examples to pattern his behavior after is largely deprived of these, particularly the boy.

In school, he is exposed to mostly female teachers, at home, to his mother. The father is out on his job. Social obligations, particularly among the more affluent parents, are such that children cannot be included. Parents may tell us that they sacrifice and do everything for their children—they give them clothes, radios, TVs, motor boats, cars—but not the company of their parents and inclusion in their lives. But as the proverb goes, children are more in need of example than in need of advice.

Many other factors leading to disturbed behavior in children could be mentioned such as parents who may be maladjusted and inadequate themselves. We closely remember the frustration of a "teen age girl of superior intelligence who had to cope with a mentally defective and emotionally unstable mother, or the bewilderment of a 10-year-old boy who was exposed to the irrational behavior of a chronically psychotic father.

But according to our experience, unless the behavior of the parents is obviously inadequate and grossly traumatic, one usually finds biological factors enhancing the stress of life and thereby causing abnormal behavioral reactions. I think we have all been impressed by the stamina many children show in face of considerably stressful situations and do not react with delinquent or neurotic behavior.

The most common causes of stress in children are constitutional overactivity and hyperactivity, specific reading disability, and low intelligence. The stress arises particularly in the school situation and may be found in children of any socio-economic background. Whenever a school-age child shows any behavioral or emotional abnormality, these three causes should be looked for. Only too frequently are they responsible for a disturbed child-parent or child-teacher relationship. It is the teacher who first has to deal with the defenses of the child. These commonly include aggressive and emotional outbursts leading to classroom disruption, or withdrawal including daydreaming and truancy. Typically the teacher will see such behavior as a threat to himself and do his utmost to change it. At first he may be sympathetic to the child and try to make adjustments. But when the disturbing behavior continues he will often use threats, force, and ridicule. A vicious circle of aggression and counter-aggression arises from which escape is almost impossible. The parents will be notified and asked to control the behavior of their child. And now the same vicious circle of aggression and counter-aggression may arise between child and parents. The

resulting personality disorder in the child and the disturbed patterns of his interpersonal relationships may continue to persist after the original cause, e.g., a strephosymbolic reading disorder, has subsided and lead to further psychiatric complications in later life.

TREATMENT

And now the question arises: What can we do about juvenile deliquency? As always, prevention is better than cure. For prevention, a comprehensive public health approach is urged. Special attention should be given to the behavior of our children in school. The teachers should be familiarized with the syndromes of motor hyperactivity, emotional overreactivity, and the specific intellectual dysfunctions. Psychiatric consultation and treatment should be available to every child who begins to show persistent troublesome behavior, who appears unhappy and withdrawn, and who is unable to cope with the academic work. Such consultation should also be made available to the teachers to help them understand the problems of the children they are to educate as well as to help them deal with their own emotional problems if they interfere with their work. Once a diagnosis has been made, treatment should be instituted immediately.

The problem we encounter earliest is that of over-reactivity and overactivity, a temperamental deviation on a constitutional basis. Treatment consists of guidance of the parents, explaining to them how this particular child differs from others and therefore may require different handling. The parents may need reassurance that the child's problematic behavior is not their fault, as they often have considerable guilt feelings about this. This stems from the wide dissemination to the public of psychoanalytic theories of the causes of disturbed behavior, placing primary emphasis on intrapsychic conflicts originating in interaction with the parents and siblings, the resulting anxiety and psychodynamic defenses. When parents understand the temperamental predisposition of their child and his resulting behavior pattern, most parents are willing and able to adjust their own behavior to fulfill the requirements of the child. Administration of phenothiazine tranquilizers is often necessary and extremely helpful in ameliorating hyperreactivity and hyperactivity as well as the associated sleep disturbances. Medication may have to be continued for years to enable the child to gain satisfaction in school, be able to accomplish the required task, and establish a favorable self-image. The use of tranquilizers does not naturally produce any permanent changes but it does control detrimental emotional and behavioral reactions of the child. It may be compared with the use of anticonvulsive medications in children with epileptic disorders—the medication controls the symptoms but does not produce any permanent changes. And just as the tendency to convulsions is outgrown by most children, so is their tendency to over-react and be overactive. A combination of counseling of parents and child and judicious administration of tranquilizing medication will generally give excellent results. If the child is presented for treatment when characterological or neurotic defenses have already developed in response to the stress created by the interaction of the temperamental abnormality of the child and its environment, intensive psychotherapy for the child may be necessary in addition.

The treatment of the reading disabilities is much less satisfactory. Minor reading retardation caused by overactivity and short attention span is usually easily corrected by remedial reading instruction as the attention span is generally much greater in a one to one relationship than in a group situation. A strephosymbolic disorder causing reading retardation is usually outgrown by the eleventh year, and remedial reading instruction is then also quite effective. Special techniques, such as reading in a mirror, may be used to help the child overcome the strephosymbolic disorder. But only too often the basic reading capacities are not intact. The training then is slow and needs constant reinforcement. There tends to be little carryover from day to day which is very discouraging to the student as well as the instructor. Many of these children will not achieve more than a fourth or fifth grade reading level even with several years of remedial instruction (*6*). The general memory of these children is usually perfectly adequate, and often we will see them memorizing whole paragraphs in their books by auditory route, reciting them, and pretending to read. The parents should be advised to read to the child, help him with his school work and, see to it that he gets at least a rudimentary knowledge of history, social science, and literature—as such knowledge contributes to the general personality development and identification with our culture and society. This should be done in addition to remedial reading instruction. If a child who cannot read is pressed to practice reading and memorize what he reads at the same time, neither end is accomplished and he will react with aversion

and eventually, hostility to school work, school, teacher, parents—delinquent behavior is the next step. One might even consider in the future teaching these children by auditory route with phonographs similar to the way blind students are being instructed.

The management of the children with low intelligence is mostly a social rather than a medical problem. They are unable to learn in the standard academic curriculum with the standard techniques. The preponderance of abstract thinking of typical school work is not suited to their intellect. They should be placed in apprenticeship or work study programs combined with continual teaching of the basic skills of reading, writing, and arithmetic, to prepare them for semiskilled or skilled vocations such as service station, bakery, restaurant, and similar services, or truck driver, mechanic's helper or even mechanic and other skilled trades. Instead of frustrating such youngsters with continuously stressing verbal skills and eventually forcing them to drop out of school, a curriculum emphasizing concrete experience and realistic vocational preparation could enable them to take pride in their performance and make them look forward to entering the job market with confidence.

The intelligent adolescent who develops an existential philosophical dilemma is generally suffering from lack of adult friends who would have a corrective influence on his thinking, or he finds adult friends who have unusual and impractical philosophical orientations themselves and with whom he identifies. In the first instance, psychotherapy will usually be very gratifying—but in the second instance, the influence of the patient's friends is difficult to counteract unless one succeeds in getting him away from his group and fulfilling his needs for companionship and approval some other way.

If a child's abnormal behavior is caused by faulty handling by the parents, advice to or treatment of the parents is imperative and will include all therapeutic techniques.

We may conclude that unless preventative programs are instituted to help the overreactive and overactive child, the child with specific intellectual deficits as well as the child with low intelligence, our schools will go on to produce unhappy, hostile and delinquent children—mental illness is not an infrequent consequence as we can readily see in our hospital admissions today. The prevention and treatment of juvenile delinquency is really prevention and treatment of emotional and mental disturbances in our children, and this is where mental hygiene should start.

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PSYCHIATRIC CAUSES OF LEARNING DISABILITY

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ABSTRACT

Learning disabilities in children are the consequence of underlying symptoms of which the best known are intellectual impairments, anxiety, and hyperactivity. But a typical or early form of affective disorders, causing elation, depression, and hyperactivity, also appear to be a frequent cause of impaired school performance.

When we look at the reasons for learning disabilities in children and adolescents, we first see the symptoms of underlying disorders which prevent a child to normally achieve in his academic work. There always are symptoms, a child never just does not want to succeed in his work. The symptoms we most frequently encounter are intellectual impairment and hyperactivity, as well as elation, depression, and anxiety. The underlying disorder then has to be determined. Intellectual impairment is caused by minimal brain damage and strephosymbolia, conditions which are well known disorders, properly classified as neurologic and which we shall therefore not discuss in this presentation, although the management is left to psychiatrists and educators rather than neurologists.

Anxiety and defenses against it is a characteristic symptom of psychologic conflict. But anxiety can arise with any condition leading to a learning disability, since an existing learning disability in itself creates a psychologic conflict in the child who is often criticized by teachers as well as parents with a resulting loss of self-esteem and his feeling "dumb." A psychologic conflict without other associated disorders will rarely cause a severe impairment of a child's intellectual performance. One is often surprised by how well children with severe psychologic conflicts can function academically. Naturally, if a severe neurotic reaction should develop for whatever reason, a child's functioning may become completely disrupted just as an adult's.

From a psychiatric viewpoint, the most important symptoms leading to interference with learning are hyperactivity and states of elation and depression.

Hyperactivity may be a symptom of minimal brain damage, but it may also be present without any evidence of any intellectual disturbance on the various psychological tests and without any abnormalities on the electroencephalogram or other neurological examinations. We call it then primary or constitutional hyperactivity. Clinical observations attest that the syndrome runs in families and is an inherited, constitutional predisposition as will be seen in the following two examples.

EXAMPLE OF CONSTITUTIONAL HYPERACTIVITY

A 7-year-old boy was referred because of restlessness and exuberant behavior in school which had become disruptive and interfered with his learning. On examination, the child was not psychotic nor neurotic and no neurophysical defects were found. He was of superior intelligence, friendly, charming, but very restless and overactive. The diagnosis of constitutional hyperactivity was made and chemotherapy was instituted to which he responded very well. The mother commented "it is now a pleasure to have him around, before treatment he was just a bundle of energy, bursting out all over." When questioned if anyone in the family had shown similar behavior tendencies, she said, "yes, I was very much like him. My nickname as a child was Lightening." She had become a dancing instructor and had found an acceptable outlet for her own motility needs.

EXAMPLE OF EMOTIONAL OVER-REACTIVITY ASSOCIATED WITH HYPERACTIVITY

A 9-year-old boy was referred because he had shown seriously disruptive and aggressive behavior

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in school and was unable to apply himself in work. He was raised by an aunt who was one year older than his mother and who lived in the same building with a 2-year-old younger sister and a family. She related that this boy had serious difficulty falling asleep and that whenever she entered his bedroom, he seemed to be awake. He would also get up at four or five in the morning and wake up other people in the house. In school, he created a continuous disturbance and was constantly involved in fights with other children. He seemed to lose his temper very readily and just recently had beaten his best friend on a minor provocation.

When questioned as to the boy's mother, she related that his mother had behaved very similarly to him. She had also been unable to sleep, disturbed her sister early in the morning, had been continually in difficulties in school, eventually began to take narcotics, became involved in prostitution, once was in a mental hospital, and also in jail. The boy had never known his mother and his aunt had raised him since infancy.

When questioned about her own parents, the aunt related that she could not remember her father who left her family when she was 2 years old. Only recently had she learned that he had died in prison.

The diagnosis of constitutional hyperactivity was made and the boy was placed on tranquilizing medication. Rather large doses were required, but then he was able to sleep normally and his aggressive behavior subsided. In this particular case, the behavioral disturbance could not have been transmitted from grandfather to daughter and to son by example.

The most interesting and least explored conditions are the affective disorders in children. Affective disorders are genetically transmitted predispositions to mood fluctuations, the most severe form of which is manic depressive illness. In treating manic depressive patients with lithium carbonate maintenance therapy to prevent a recurrence of either manic or depressive episodes, we noted that many patients stated that they felt "more mature." When questioned, the patients explained that their mood generally was more stable, that they had more control over themselves. These patients had been suffering from frequent subpsychotic mood swings which were now controlled by lithium. Now that our attention was focused on these subpsychotic mood swings in known manic depressives, they reminded us of similar mood patterns in adolescents who showed sharp mood swings with depressions and elations, with or without hyperactivity. Lithium appeared to be quite effective in controlling symptoms in these patients and therefore suggests the possibility that patients with hyperactivity and emotional lability may be early or atypical cases of manic depressive illness. For example, one patient was treated for a primary hyperactive behavior syndrome for three years with tranquilizing medication and psychotherapy. At the age of fourteen, he developed a severe depression and when treated with electroconvulsive therapy, went into a hyperactive and hypomanic state. He was then placed on lithium carbonate and showed distinct improvement with considerable lessening of the hyperactivity and emotional lability, now giving the appearance of "being more mature." His academic work improved considerably.

In summary, minimal brain damage, strephosymbolia, and psychological conflicts are well known to cause learning impairments. It is suggested that early or atypical forms of affective disorders are a frequent cause of impaired learning and further research done in this area.

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PSYCHIATRIC PROBLEMS IN EVALUATING FITNESS FOR MILITARY SERVICE

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ABSTRACT

The Armed Forces accepts annually an average of 20,000 men who should have been rejected for medical defects which existed prior to entry into military service (EPTS). In the fiscal year 1968, 12.3% of these were for psychiatric illness. This did not include discharges of inductees diagnosed as having personality disorders which also should have been included as psychiatric conditions thereby increasing the number of the latter. The authors strongly recommend that the psychiatric examination techniques, as set forth in Army Regulation AR 40-501, are amended to include a more thorough personal and familial history, in addition to the mental status examination, since many psychiatric disorders are characterized by remissions when no symptoms are present. Malingering and "beningering" also can cause problems to the AFEES psychiatrist and in every suspected case, a further investigation and study should be made before mistakenly qualifying such a registrant for military service. Army regulations of medical fitness for psychiatry are discussed.

The recognition of psychiatric disorders in pre-inductees is often difficult for three main reasons:

1. There is not a sufficient number of psychiatrically-trained and experienced personnel to examine every pre-inductee.

2. In order to establish the diagnosis of psychiatric illness, the current mental status alone is not sufficient, because in certain psychiatric disorders, there are intervals when there are no symptoms. If during such a remission a pre-inductee does not give a history of psychiatric illness or in fact denies any such history, it would be impossible at that time to discover his psychiatric problem.

3. The frequent assumption that a pre-inductee will readily admit to, or even exaggerate, the presence of psychiatric symptoms in order to escape the draft is unwarranted. Even if a history of psychiatric disorder is given, the examining psychiatrist, overly suspicious of malingering, may choose to ignore it, and therefore, mistakenly qualify the registrant.

At present, no psychiatric examination is given to a pre-inductee unless he:

(a). Has a history of recognized psychiatric disorder prior to his pre-induction physical examination and reports so and

(b). Checks certain items on a screening questionnaire.

Regarding the first of the above-mentioned factors which makes detection of psychiatric disorders difficult, it is apparent that considering the number of available psychiatrists and the number of registrants, it will not be possible to give every registrant (pre-inductee) an examination because of the shortage of psychiatrists. The assumption that a pre-inductee will invariably admit to and report the presence of psychiatric symptoms is fallacious. The tendency of people to hide the presence of psychiatric problems in themselves and in their family members is well known, as psychiatric problems are thought to be a moral weakness and a sign of inferiority. In addi-

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tion, many registrants (as well as their families) feel and hope that the army will "straighten me out" and "make a man out of me." This leads to a phenomenon which we choose to call "beningering," as an antonym of malingering.

Three different studies were made in which two comparable groups of 200 men each answered a self-rating test (Neuropsychiatric Screening Adjunct), one group under conditions of anonymity and the other being instructed to sign their names. Two of these studies were made among men in the army. The third was made in an Armed Forces Examining and Entrance Station (AFEES). The identified groups consistently reported less symptoms.

Case No. 1. A. L. had always been an impulsive, high-strung boy who had considerable difficulties adjusting to his home, school, and society at large. During adolescence, he became involved in drug abuse, including heroin. He did not consider himself addicted; although when he attempted to stop using heroin, he experienced withdrawal symptoms. A psychiatrist who had been consulted felt that there was nothing he could do to help him as long as "A" continued to use heroin. When his draft date approached, "A," who considered himself weak and bad rather than psychiatrically ill, felt that the army would "cure" him and "make me grow up." His own "badness" including the use of heroin he did not mention. Result—after several months in the service, he became increasingly irritable and depressed and had to be hospitalized in an army hospital where he was treated for several months and then received a psychiatric discharge. Afterwards, he became re-addicted to heroin and increasingly depressed, had to be hospitalized in a civilian hospital, and eventually was placed on Methadone maintenance treatment for heroin addiction and received continued anti-depressive treatment (Triavil and Elavil).

Case No. 2. J. R. had been a homosexual since early adolescence, first in fantasy, then in actuality. He was so neurotic that even socially, he could not be in company with a woman without experiencing anxiety and at times, panic attacks. He was terribly ashamed of his affliction and considered becoming a priest in order to have a socially acceptable excuse for not getting married. His feelings of shame, guilt, and anxiety were drowned in alcohol. When his induction approached, he was too ashamed to admit to homosexuality. Result after some time in the service, he felt increasingly isolated, unable to identify with others, anxious, depressed, and unable to continue this life. To admit to his affliction at that time "would have been impossible." He decided to fake an accident and shoot himself. He really did not care too much if he would kill himself in the process. He injured himself badly and almost died, received a medical, non-psychiatric, discharge and lifelong partial disability payments. After discharge, he continued to be excessively neurotic, became an alcoholic and eventually sought psychiatric help. After joining ALCOHOLICS ANONYMOUS and with several years of intensive psychotherapy, he developed into a socially-productive, hardworking, well-adjusted homosexual.

The *criteria given for psychiatry* in the army standards of medical fitness 1960, AR 40-501, Chapter 2, *PROCUREMENT MEDICAL FITNESS STANDARDS,* in the main appear to be comprehensive and excellent. In Section XVI under the title of *PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS* they are:

2-32. *Psychoses*

The causes for rejection for appointment, enlistment, and induction are—

Psychosis or authenticated history of a psychotic illness other than those of a brief duration associated with a toxic or infectious process.

2-33. *Psychoneuroses*

The causes for rejection for appointment, enlistment, and induction are—

(a) History of a psychoneurotic reaction which caused—

1. Hospitalization
2. Prolonged care by a physician
3. Loss of time from normal pursuits for repeated periods even if of brief duration, or
4. Symptoms or behavior of repeated nature which impaired school or work efficiency.

(b) History of a brief psychoneurotic reaction or nervous disturbance within the preceding twelve months which was sufficiently severe to require medical attention or absence from work or school for a brief period (maximum of seven days).

2-34. *Personality Disorders*

The causes for rejection for appointment, enlistment, and induction are—

(a) Character and behavior disorders, as evidenced by—

1. Frequent encounters with law enforcement agencies, or anti-social attitudes or behavior which, while not a cause for administrative rejection, are tangible evidence of an impaired characterological capacity to adapt to the military service
2. Overt homosexuality or other forms of sexual deviant practices such as exhibitionism, transvestism, voyeurism, etc.
3. Chronic alcoholism or alcohol addiction
4. Drug addiction.

(b) Character and behavior disorders where it is evident by history and objective examination that the degree of immaturity, instability, personality inadequacy, and dependency will seriously interfere with adjustment in the military service as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow-workers, and other society groups.

(c) Other symptomatic immaturity reactions such as authenticated evidence of enuresis which is habitual or persistent, not due to an organic condition (para 2-15c) occurring beyond early adolescence (age 12 to 14) and stammering or stuttering of such a degree that the individual is normally unable to express himself clearly or to repeat commands.

(d) Specific learning defects secondary to organic or functional mental disorders.

Our own case histories indicate that the above criteria were not always followed.

Case No. 3. A manic depressive patient had a history of two psychiatric hospitalizations prior to induction at a time when the 1960 army criteria were in effect. He had no knowledge of draft procedures and he had no intention of avoiding the draft. At the time of the pre-induction physical examination, he gave his history of two psychiatric hospitalizations. The registrant did not know his diagnosis. He was a manic depressive patient in remission. The examining AFEES psychiatrist found the patient's mental status to be normal and decided that he was suitable for military service. Result—several months after induction, the patient had another psychotic depression, spent quite some time in army hospitals and was then discharged. He has had several psychotic episodes since.

As previously pointed out, we must rely on the history to elicit criteria for the presence of psychiatric disorders most of which are characterized by a tendency to remission and recurrence. A pre-inductee is too frequently suspected of malingering but rarely ever of "beningering."

Case No. 4. A patient had been under psychiatric care since the age of 14 for a depressive disorder with obsessive compulsive features which had led him to submit repeatedly to plastic surgery. Psychiatric hospitalization became necessary and after discharge, psychotherapy was continued. When the registration for draft approached, the patient was advised that in the opinion of the treating psychiatrist he was not fit for military service, considering that most of the time the patient could hardly function in everyday life and was always in danger of being re-hospitalized. The patient, on the other hand, felt that he was suited for military service, stated the symptoms were "not too bad, really not bad at all." After all, at times he was functioning quite well and he felt that maybe the army would straighten him out. Also, he was worried how it would look on his record if he had a 4F classification. The psychiatrist eventually convinced him that he had to tell the truth to the examining army physicians and a psychiatric report with his case history was sent to the proper authorities. The registrant was asked to get an additional statement from the hospital after which he was disqualified for military service. He has had several incapacitating episodes of illness since.

Only if we accept the history given by a registrant and in addition, look to screening out the "beninger-er," are we able to follow any set criteria for exclusion from military service on psychiatric grounds. Experience has shown that when strict criteria are applied, as were used in the Navy in selecting males for isolated duty in the antarctic, no cases of psychiatric illness arose.

It has been shown that the standards of medical fitness for the U. S. Army as set forth in December 1960 are not regularly followed by the Armed Forces Examining and Entrance Stations (AFEES). This becomes painfully clear when for example the New York Daily News, on Thursday, July 9, 1970 carried the following: "ex-mental patient court-martialed today. Twenty-seven-year-old-soldier, drafted into the army despite his long history of mental illness and prior confinement in state mental hospitals goes on trial for desertion at Fort Dix, New Jersey today. . . . He was inducted after he apparently failed to inform the military of his history of mental illness. However, while in basic training, his mother repeatedly wrote to his commanding officer about his background to explain his difficulties in completing the course. . . . The army wrote back to the mother saying John would make a fine soldier if he only

changes his attitudes."

Apparently this induction took place because the patient had not informed the AFEES physician of his history. However, registrants have been inducted who had informed the AFEES of such prior history. (See *Case No. 3.*)

It should be noted that in Army Regulations AR 40-501, 11-21, *Medical Examination Techniques, Section XIX, Psychiatric,* listed below, **the AFEES psychiatrist is not required to obtain a history, in fact, there is no mention of case history.**

11-21. *Psychiatric*

(a) During the psychiatric interview the examining physician must evaluate each individual sufficiently to eliminate those with symptoms of a degree that would impair their effective performance of duty.

(b) The psychiatric interview will be conducted subsequent to the completion of all items on SF 88 and 89. During the interview, the examinee's behavior will be observed and an estimate made of his current mental status. Any evidence of disorganized or unclear thinking, of unusual thought control, of undue suspiciousness or of apathy or "strangeness" will be noted. Any unusual emotional expression such as depression, expansiveness, withdrawal or marked anxiety, which is out of keeping with the content of the interview will be carefully evaluated.

(c) The results of the psychiatric examination will be recorded on SF 88, item 42, as normal or abnormal in the space provided. If the individual is disqualified, the defect will also be recorded in item 74, SF 88.

The induction of personnel in the Armed Forces with medical defects existing prior to service (EPTS) is a continuous problem to the U. S. Army Recruiting Command (USAREC), (Sgalitzer). In the fiscal years 1968 and 1969 there were 39,400 discharges for EPTS conditions. An analysis of the major contributing factors to these errors in inductions were:

"1. Ignorance on the part of medical examiners of pertinent military regulations. This is a particularly large factor in AFEES which do the greatest number of medical examinations. In these AFEES numerous civilian physicians are used to supplement military medical personnel. These physicians are less likely to be familiar with military regulations, especially during their breaking in period."

"2. Large numbers of highly motivated applicants for enlistment will conceal potentially disqualifying defects, to avoid being disqualified for the Armed Forces. This is probably the most difficult of all the major reasons for EPTS discharges to effectively control." *(The authors choose to call this 'beninger-ing'.)*

"3. As in most organizations such as the AFEES, the professional motivation and medical knowledge of the individual examining officer are the most important factors. This holds true regardless of the workload or the station size."

Forty thousand (for 1968 and 1969) or 12.3% of the EPTS discharges were neuropsychiatric. This figure is distorted because of the military *double standard regarding personality disorders. In the physical examination of registrants, personality disorders are considered psychiatric conditions* and prospective inductees with personality disorders of sufficient severity will be disqualified from service for medical reasons. If the AFEES psychiatrist qualified a registrant with a personality disorder as fit for military service and later it develops that the inductee is unable to function in a military setting, he then will be dealt with "through appropriate administrative channels" ranging from court-martials and stockades to administrative separation. The 12.3% neuropsychiatric discharges refer therefore only to psychoses or psychoneuroses. **It is apparent that if personality disorders were included, the percentage would be much higher.**

Army Regulation 40-501, Chapter 3, RETENTION MEDICAL FITNESS STANDARDS, Section XV, *PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS.*

3-29. *Psychoses*

Recurrent psychotic episodes, existing symptoms or residuals thereof, or a recent history of psychotic reaction sufficient to interfere with performance of duty or with social adjustment.

3-30. *Psychoneuroses*

Persistence or severity of symptoms sufficient to require frequent hospitalization, or the lack of improvement of symptoms by hospitalization, or the the necessity for duty in a very protected environment. **(Incapacity because of neurosis must be distinguished from weakness of motivation or underlying personality disorder.)**

3-31. *Personality Disorders*

(a) Character and behavior disorders. Character and behavior disorders are considered *to render an individual administratively unfit rather than unfit because of physical disability.* Interference with performance of effective duty will be *dealt with through appropriate administrative channels.*

(b) Transient personality disruptions. Transient personality disruptions of a nonpsychotic nature and situational maladjustments due to acute or special stress do not render an individual unfit because of physical disability.

(c) Sexual deviate. Confirmation of abnormal sexual practices which are not a manifestation of psychiatric disease provides a basis for medical recommendation for administrative separation or other nondisability disposition.

3-32. *Disorders of Intelligence*

Individuals determined to have primary mental deficiency or special learning defect of such degree as to interfere with the satisfactory performance of duty are administratively unfit and should be recommended for administrative separation.

AR 40-501, APPENDIX I, DEFINITIONS

9. *Physical Disability*

Any manifest or latent impairment of function due to disease or injury, regardless of the degree of impairment, which reduces or precludes an individual's actual or presumed ability to perform military duty. The presence of physical disability does not necessarily require a finding of unfitness for duty. The term "*physical disability*" *includes mental diseases other than such inherent defects as behavior disorders, personality disorders, and primary mental deficiency.*

What are the psychiatric conditions encountered in the military personnel? (Caldwell)

"1. Classic psychoneuroses are practically nonexistent.
2. Most of the schizophrenic disorders are of the acute undifferentiated or paranoid type.
3. Depressions accompanied by vegetative or physiologic changes are quite rare, but manic reactions are encountered occasionally.
4. The prevalent reactions are those characterized by anxiety, 'feelings of depression,' and personality difficulties."

Points three and four bear out a blind spot toward depressive illness not only among military psychiatrists, but among psychiatrists in general. Depressive states are much more common than manic states, but only too often they are diagnosed as schizophrenia, particularly pseudo-neurotic or paranoid type, neurosis, or personality disorder. There is a distinct tendency among many psychiatrists to make a diagnosis based chiefly on thinking disturbances and to mistakenly ignore the primary mood alterations.

Since the syndrome of depression is very frequently encountered, a short discussion of depressive illness (endogenous depression, classified in the American Psychiatric Assn. *Diagnostic and Statistical Manual of Mental Disorders,* Second Edition, 1968, as manic-depressive illness, depressed type) would seem indicated.

1. Depression is a syndrome consisting of the following most common symptoms: (a) withdrawal from the environment; (b) inability to relate to other people normally; (c) irritability, anger, violent impulses, and hostility; (d) lack of energy and difficulty or inability to perform usual tasks; (e) inability to concentrate and to think clearly; (f) excessive worrying; (g) strong feelings of inferiority which may progress to feelings of unworthiness; (h) feelings of guilt; (i) pervasive pessimism; (j) feelings of hopelessness and despair; (k) feelings of anxiety, nervousness, and tension; (l) hypochondriacal complaints; (m) suici-; dal thoughts, contemplations, and eventually attempts and/or suicide; and (n) accompanying paranoid ideation is frequent, obsessive compulsive symptoms less so.

It is not uncommon for the patient to complain of various of the above symptoms and *not even mention* "feelings of depression." Considering that the patient thinks it normal to feel depressed if one has such symptoms as he is complaining of, this is understandable. The diagnosis is, therefore, frequently missed.

2. Depressions (endogenous) are characterized by remissions and recurrences usually without any apparent cause. Once in existence, stress will enhance them. It is more difficult to determine how often stress precipitates them, as people are always looking for a reason and we all usually have something to be "depressed" about. But if stress triggers off a depression, the emotional reaction will be out of proportion to the precipitating event as judged by what one would ordinarily expect in the average person.

States of depression may last from hours, or rarely even minutes, to years, and recurrences may be very frequent or very rare. It is to be kept in mind that endogenous depressions may recur at any time without any apparent reason.

A patient suffering from recurrent, endogenous depressions may also at any time develop a manic elation, though manic states are much less frequent than depressive states. Manic depressive illnesses are biologic disorders which are genetically trans-

Psychiatric Problems in Evaluating Fitness for Military Service—*Stevens et al.*

mitted and therefore show a strong familial incidence. This was clearly demonstrated by Kalmann in hospitalized patients with the diagnosis of manic-depressive illness. Kraepelin included all depressive and manic disorders as "merely forms of one single disease process" which had a common although yet undiscovered biologic cause. With the advent of psychoanalysis and the observations that some typical cases of manic-depressive illness were seemingly triggered off by psychologic events, this was questioned and a distinction between neurotic and psychotic (endogenous) depression was emphasized.

The tendency has prevailed to ascribe depressions to psychogenic conflicts. The depressed patient was, and is, the ideal subject for psychoanalysis. He suffers and is therefore highly motivated for treatment. He is usually not sufficiently incapacitated to be hospitalized and therefore accessible to office treatment. He is usually of the compulsive personality type and therefore takes care of his obligations. Depressions are usually characterized by exacerbation and remission. When under treatment a remission occurs, the patient feels that he has solved the problem and this proves to him the efficacy of the treatment. Being usually compulsive, he wants to solve all his unconscious conflicts. When exacerbation occurs, he knows that there are still unresolved conflicts which increases his motivation to continue with psychoanalysis. It is not unusual for patients who have been under treatment for long periods of time to have worse depressive episodes than they had before. This is not a result of the treatment, but because depressions often have a tendency to increase with advancing age.

In our clinical experience of many years in the treatment of manic-depressive illness using all forms of psychotherapy and psychoanalysis, pharmacotherapy including an investigative study of over 200 patients with lithium carbonate therapy, also convulsive therapy (electro-convulsive and Indoklon), we have come to the following conclusions:

1. Manic-depressive illness is a genetically caused instability of the mood and occurs without apparent psychological cause. Psychological stress may trigger off depressive or manic states in genetically predisposed individuals. Persons not so predisposed experience sadness and happiness, but not depressive or manic states. An intellectual decision to commit suicide in the face of unbearable psychologic conflict is not a sign of depression and will change immediately if the conflict can be resolved.

Case No. 5. A happily married and sexually well-adjusted male in his 40's was hospitalized after he attempted suicide. He felt hopeless, stated he was turning into a homosexual and therefore would rather commit suicide than disgrace his family. The history revealed that the patient had had a bilateral inguinal hernia for which a bilateral herniorraphy was performed. Thereafter, he developed bilateral testicular atrophy. He noticed a change in his body configuration, and his testicles and penis became smaller. He was a member of an athletic club and while taking showers with other men, began to compare his own genitals with theirs in an obsessive manner. Shortly after he was placed on Testosterone maintenance treatment, he consulted a psychiatrist because of his continued obsessive watching of other males in the shower room. He was told that his unconscious homosexuality was becoming manifest and that he needed long-term psychoanalytic treatment to get cured. He became very upset and thereafter, decided to commit suicide.

When it was explained to him forcefully by two psychiatrists that his symptoms had absolutely nothing to do with homosexuality, and that they were an expected reaction, secondary to his hormonal deficit which was now being corrected by medications, his mood immediately changed, suicidal ideation disappeared, and he could be discharged from the hospital after one day. Psychiatric follow-up care showed that the obsessive watching of other males disappeared and no depressive or suicidal ideation returned.

2. Manic-depressive illness is often misdiagnosed as schizophrenia, psychoneurosis, personality disorder, or medical illness (for example, infectious mononucleosis, hepatitis, gastro-intestinal disturbances, etc.)

Case No. 6. A male in his 20's was referred for psychotherapy. He explained that he had several past psychiatric hospitalizations and that he had seen his diagnosis to be paranoid schizophrenic by peeking at his hospital records. No schizophrenic symptoms were elicited, and the patient was generally guillible rather than paranoid. Sometime after treatment was started, he became over-active, elated, grandiose, overly self-confident, markedly paranoid and started to verbally attack people including his superiors at work. He had to be hospitalized and was placed on Phenothiazine tranquilizers. In the hospital, he went into a state of suicidal depression. In the depressed state, no paranoid symptoms were present. He had to be treated with electroconvulsive therapy and symptoms disappeared. He has had several psychotic episodes since, following exactly the same pattern. The diagnosis of manic-depressive illness, cyclic type, with paranoid features was made, and the patient was eventually placed on Lithium Carbonate maintenance treatment.

3. Depressive and manic states are not amenable to psychotherapy alone but do respond well when it is combined with pharmacotherapy and or convulsive therapy. If secondary psychologic conflicts have arisen because of the primary mood disorder they will respond to psychotherapy after the mood disorder has been controlled by pharmacotherapy or convulsive therapy, or if it has subsided spontaneously.

4. Preventive measures directed against a recurrence of manic or depressive episodes, consists of:

(a) Maintenance pharmacotherapy (lithium carbonate, tricyclic anti-depressants with or without tranquilizers and amphetamines).

(b) Maintenance convulsive therapy (bilateral and unilateral electro-convulsive therapy, or Indoklon convulsive therapy).

(c) Psychotherapy to resolve existing psychological conflicts to guide the patient into a life of least possible stress in patients in whom mood alterations appear to be frequently triggered off by stress.

5. The diagnosis of manic-depressive illness in remission depends on a thorough personal and familial history.

To summarize, we see the following problems in the recruitment of pre-inductees:

1. Although the 1960 Army Medical Fitness Standards are excellent, they are not always followed by the examining psychiatrists.

2. The main reason for this appears to be that many psychiatric illnesses have symptom free intervals. Therefore, the diagnosis depends mostly on the history, rather than solely on a mental status examination.

3. It has been pointed out by the United States Army Recruiting Command that the concealment of potentially disqualifying defects, "beningering," is a most important cause for discharge of servicemen because of the pre-existing medical conditions. If the examining AFEES psychiatrist because of suspected malingering, refuses to accept or ignores the history without further investigation, he may mistakenly qualify the registrant.

4. If a registrant is inducted into the Armed Forces against existing medical standards of fitness by error of the examining AFEES psychiatrist, the inductee will be placed in serious jeopardy if his condition is diagnosed as a **personality disorder.** He then will not be treated medically but would be subject to *military administrative procedures* which could include court-martial.

5. The military spent in the fiscal year 1967, 19.6 million dollars and in 1969, 17.9 million for pay, uniform, and travel of soldiers who were discharged because of pre-service defects. Psychiatric disorders totaled 12.3% and if personality disorders were included, the percentage would be much higher.

The tax payer finally carries the burden which would be lessened in the future by improved screening of registrants and enlistees for military service.

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Psychiatric Rejects from Military Service and Their Employability in Civilian Life

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In evaluating the employability of psychiatric rejects from military service, one must consider their functional capacity during the remissions of their illness, the frequency and duration of these remissions, and their records of tolerance to stress. It is not the diagnosis per se which determines the capacity for employment, but the intensity and frequency of the illness, whether it be schizophrenic, manic depressive illness, neurosis, psychosomatic disorders, personality disorders, or mental deficiency. A factor often overlooked is that proper employment for such persons is often an aid to their becoming healthier mentally.

There are thousands of psychiatric rejects from military service as well as others, who suffer from mental disorders ranging from mild to severe, but who can be employed either full-time or part-time according to the nature and intensity of their illness. The Armed Forces accepts annually an average of 20,000 men who should have been rejected for medical defects which existed prior to entry into military service. In the fiscal year 1968, for instance, 12.3% of these rejects were for psychiatric illness. This did not include discharges of inductees diagnosed as having *personality disorders* which should also have been considered as psychiatric conditions, thereby substantially increasing the total number of psychiatric rejects.

The majority of those suffering from psychiatric disorders have periods of remission during which they are totally or partially free of their symptoms. During this time their ability to tolerate stress may not be impaired. However, if it is, such persons with the help of psychiatric treatment often can withstand the stress of everyday life as well as the stress in their working situation.

A factor often overlooked is that employment for such persons may be equivalent to occupational therapy and may actually be an aid to their becoming healthier mentally. The self-esteem created by employability cannot be overestimated. Everyone needs to feel he is productive and is receiving compensation for his efforts. This is especially true of those suffering from psychiatric disorders since their self-esteem has often been severely damaged.

A twenty-one year old man was unable to concentrate on study or work for three years. He dropped out of college and allowed his mother, a widow, to support him. Although she gave generously, he resented not being able to earn his own living. After several months of psychiatric treatment, he improved sufficiently to become employable. It was suggested to him that he try to get a job and support himself, and he was told that if he could do so, his hostility to his mother would lessen, and his own self-esteem would increase. The idea of building up self-esteem, something he did not think he would possess, appealed to him. He went to work as a waiter in a restaurant, earning enough to support himself. His self-esteem increased markedly, and he continued to make progress in therapy.

A fairly high percentage of psychiatric rejects from military service, as well as civilians, suffer from neurosis, schizophrenia, manic-depressive illness, psychosomatic disorders, personality disorders, homosexuality, learning disability, and mental retardation. Alcoholism and drug abuse are often complicating factors. Whatever the diagnosis, in determining the employability of the emotionally disturbed individual, the following three factors should be taken into consideration: 1) remission personality (how a person functions during a period of remission); 2) frequency and duration of remissions; 3) tolerance to stress.

These three factors can be improved or controlled by psychiatric treatment, which includes psychotherapy, pharmacotherapy and/or convulsive therapy.

Many people suffering from neurosis, schizophrenia, manic-depressive illness, or personality disorders, can function either full-time or part-time, particularly if they are receiving psychiatric treatment. Many of these

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persons are intelligent and, if the working condition corresponds to their capacity, operate efficiently.

SCHIZOPHRENIA

Many schizophrenics work as well as anyone else in certain job situations. For example, a paranoid schizophrenic was selling stamps in a post office, a sheltered situation. He did not have to come into close contact with other people and he could be impersonal in his dealings with the public. The window behind which he was sitting created a realstic "fence" between him and the one who was purchasing stamps, and between him and the outer world which he felt to be a hostile one. At the same time, his obsessive compulsive needs were fulfilled by the type of work he was doing.

A young man of twenty-five, diagnosed "hebephrenic schizophrenia," with predominant symptoms of giggling or laughing nervously, has been treated with psychotherapy for five years. At first he was unable to hold a job and had no ability to concentrate, to study or to learn. He was very athletic and a champion swimmer. Even minor mathematics was too much for him. He would ask, "Is there much difference between $100,000 and $1,000,000?" He also at times had delusions about his father in which the latter would appear as a reptile. As gradual improvements took place, and with encouragement, he attended and graduated from a special school for under-achievers in New York City and is now working in a library.

Occasionally, someone who has delusions of persecution may cause others to feel angry and irritated, and even threatened physically. But most of the delusions of schizophrenics are harmless. Nevertheless, if the presence of delusion is noted, psychiatric treatment should be initiated.

MANIC DEPRESSIVE ILLNESS

Depression, a common symptom, may indicate the presence of manic depressive illness which arises unpredictably and without apparent reason, although it may at times be brought on and enhanced by stress. Manic states, or states of a mood elation, follow a similar pattern, but are much less frequent. A manic depressive patient may be unable to function during the acute phase of the illness, but in the interim period, when he is free of the excessive emotions of either elation or depression, he is able to act and function normally. Many of these patients have long intervals of remission and have been producing far above average.

One of America's outstanding architects, when a young man, had been discharged from military service during World War II. Since then, he has had several episodes of manic depressive illness which were quickly controlled by psychiatric treatment and convulsive therapy. In states of remission, he was extremely creative and productive.

A young man was inducted into the Armed Forces despite a prior history of two psychiatric hospitalizations. In service, he developed another psychotic episode and after remission was discharged. Since then, he was able to build up his own business and was financially quite successful in spite of two further psychotic episodes necessitating psychiatric intervention.

NEUROSIS

The term "neurosis" has been widely and loosely used in recent years, meaning all things to all men. More often than not, it is used to describe almost any kind of peculiar behavior. It includes the worried person, the anxious person, the depressed person, the person who cannot marry, the person who marries too often, the person who over-eats; of all these, someone is apt to say scornfully, "He's a neurotic! "

Most people with a neurosis are able to work. As a matter of fact, the compulsive neurotic works much harder than the average person. He is successful in spite of his neurosis and perhaps, also, because of it. Many of our genuises, in business, in science, and the arts, were very neurotic people. Many of the world's achievements were undoubtedly made by neurotics. The emotionally calm, secure men and women have no need to "over-achieve." They are content with the small pleasures of life.

A young man was discharged from military service with a severe anxiety neurosis complicated by alcoholism. He accepted a position as a clerk in a shipping department. At first his work record was poor because of periodic flare-ups of anxiety and heavy drinking. He entered psychotherapy and gradually improved. He became the most reliable employee, and after ten years was placed in charge of the department which he since has run successfully.

PSYCHOSOMATIC DISORDERS

The person who suffers from psychosomatic disorders is apt to lose working days because of his physical complaints. Most psychosomatic complaints have their root in emotional problems. As a person undergoes psychotherapy, his symptoms frequently disappear, whether they be migraine headaches, stomach pain, chest pains, and so on. Physical illness may be a way the body has to try to help someone whose mind is overwhelmed with emotional conflict, as mind and body work together in the battle for psychic survival.

A young man was suffering from severe migraine headaches which often lasted one to two days and during this time incapacitated him completely. He was forced to stay in bed in a darkened room. He was rejected from military service and often had to take off time from work. During psychotherapy, it was noted that the headaches were preceded by psychologic conflicts in which he was resentful of the behavior of his

family, but unable to speak up and assert himself. As he resolved his psychologic conflicts, the migraine headaches disappeared almost completely and his working record improved markedly.

LEARNING DISABILITIES

The most common learning disability — primary reading — interfering with job performance is a constitutional defect, present in about 5% of any given population and several times more frequent in boys than in girls. Young men with a reading disability of sufficient severity may be rejected from military service because of their inability to follow written instructions and to communicate with their families in writing. Since their other intellectual functions are not impaired and may even be superior, such persons often do extremely well in jobs in which reading is not required, particularly if management gives them appropriate work and shows an understanding attitude and appreciation of their other capabilities. The self-esteem of such people is often severely damaged, they consider themselves "dummies," and if helped to function and achieve are usually very thankful.

A young man was a non-reader despite intensive remedial reading instruction during elementary and high school. His self-esteem was very low and his predominant mood was one of depression. He felt hopeless about his situation and the future. In psychotherapy it was pointed out to him that he was not "dumb," and he was suffering from a common disorder afflicting many people, that this was not his fault, and that he could function quite well in other areas. When applying for a job as an automobile mechanic, he was encouraged to tell his employer about his disability rather than trying to hide it, as this would have been impossible in the long run anyhow. After some hesitation, he agreed to do so and was highly amazed that he was hired, nevertheless. He was assigned to perform manual tasks. He is enjoying his work and is very grateful to his employer for his understanding attitude.

MENTAL DEFICIENCY

People who are mentally deficient can often do minor tasks with some degree of reliability if the task is geared to their intellectual capacity. They often need a sheltered work situation which provides a maximum degree of supervision.

HOMOSEXUALITY

A number of psychiatric rejects from military service are young homosexual males. Homosexuals are as employable as anyone else, for the sexual conflict of the homosexual usually will not interfere with his functioning on the job. Difficulties may arise when a homosexual is held in contempt by some of those with whom he works, possibly if he has an effeminate manner. In the past, the average man and woman did not understand that the homosexual cannot help his abnormal sexual desires and behavior. Recently, the public has become much more tolerant and working problems of homosexuals have considerably decreased.

ALCOHOLISM AND DRUG ABUSE

Alcoholism and drug abuse are often secondary symptoms to a primary psychiatric disorder. Industry has more than 2,000,000 alcoholics on its payroll. The alcoholic's accident rate is about twice that of the non-alcoholic. He loses from 25 to 30 working days each year because of his drinking, and much of the remainder of the time he is likely to be working at a low level of efficiency. There is apt to be a slowdown in production when an alcoholic is part of a team.

Because the onset of alcoholism is slow and excesses occur only periodically, a problem drinker may conceal the degree of his drinking until he has become a full-blown alcoholic. He denies to himself and others that he has a "problem," when all the time he should be getting help for what is a progessive illness. Psychiatrists recognize in general *three types of problem drinkers:* 1) the chronic alcoholic who starts drinking socially and gradually consumes more and more; 2) the reactive drinker who does not drink much as long as his life is smooth, but turns to alcohol as solace when under stress; and 3) the symptomatic drinker whose alcoholism is only one symptom of a more severe psychiatric illness.

As he drinks more and more over a longer and longer period of time, the alcoholic's self-control lessens, his work suffers and so does his health and family relationships. If the alcoholism is severe, he may have alcoholic blackouts and even delirium tremens, although the latter hardly ever occurs in the job setting, for by that time the alcoholic usually has lost his job. Psychiatric treatment, if instituted in time, can prevent this in a fair number of cases.

A man in his fifties was referred for treatment for alcoholism. He was intoxicated, loud, noisy, over-active, and restless. He appeared to be in good spirits, but became irritable at the slightest provocation. The history revealed that he had started in his company as an errand boy and worked himself up to be a partner. Despite the fact that he had been suffering from "alcoholism" since his late twenties, he was an apparent success. He showed periods of heavy drinking when he would go out to bars and spend much money, buying drinks for everyone, then going home where he became excessively irritable and at times physically assaultive. He was jailed once for his behavior, and hospitalized on other occasions. Normally, he did not drink much and had only one or two cocktails occasionally when going out to dinner. The presumptive diagnosis of a manic depressive illness, manic type with secondary alcohol abuse, was made and further investigated.

His closest business associate, also a partner in the firm, was questioned as to whether he noticed anything about the patient's behavior prior to the onset of the drinking. After thinking about this, he explained that he noticed that the patient would become over-active, short-tempered with the secretaries, and would start speaking in a hoarse and loud voice. A few days later the drinking would begin. The diagnosis and the clinical picture was interpreted to the patient and his partner, and his partner was asked to send the patient immediately for psychiatric treatment, when he noticed symptoms arising. The patient and the partner followed through on this arrangement, and the patient presented himself for treatment repeatedly with hypomanic states prior to the onset of drinking, which could be controlled with psycho-active medications. Thus, the diagnosis could be confirmed and the "alcoholism" subsided. Once the patient remarked: "This is the funniest sickness I have ever had. Whenever I'm beginning to feel good, I have to see a doctor."

Drug Abuse

Drug abuse in many cases is symptomatic of underlying psychiatric disturbance and the prognosis will depend on the underlying disorder. This holds true for abusers of the hallucinogenic drugs, including marijuana, the amphetamines, the barbiturates, and other sleeping pills, as well as cocaine.

The only true addicting drugs are the narcotic drugs, namely, the opiates and the synthetic non-opiate narcotics. The abuse of narcotic drugs usually starts with experimentation, which occurs without an underlying psychiatric disorder. After a period of time the person becomes addicted in the sense that a new craving similar to an instinctual urge has been created. This process can take place in otherwise emotionally healthy people. This is, in general medical practice, the reason why narcotic drugs are used sparingly, and only when absolutely necessary. The criminal behavior of a narcotic addict is the result of the need for the narcotic drug which has to be satisfied. It has been shown that the majority of patients in whom the addictive craving was controlled by continuous administration of methadone (methadone-maintenance treatment) were able to return to a normal life, accept employment and hold jobs, and give up their criminal activities. A person whose narcotic addiction has been controlled by methadone and who is free of any other disabling psychiatric illness can be employed in any capacity.

A man in his early thirties had become addicted to heroine in his late teens and over the past 15 years had been in and out of hospitals and jails continually. He presented himself for treatment stating that he had just been released from jail two weeks ago, was on probation, and again had started taking narcotics in the form of cough syrups with codeine. He said he knew he would go back to heroine and be back in jail again unless he could be treated with methadone. He was placed on methadone-maintenance treatment as an in-patient in a hospital. Within the week after discharge he accepted employment as a truck driver and for over two years has been regularly employed with the same company. He has received no additional psychiatric treatment.

INDUSTRIAL PSYCHIATRISTS

More and more psychiatrists are being used not only as consultants to industry but on the staff of corporations. The industrial psychiatrist, as he is called, works closely with the personnel department, one of whose goals is to develop a sense of belonging on the part of employees, which means understanding them psychologically. Both psychiatrists and psychologists throughout the country are working to interest industrial management in accepting an informed psychologic approach to personal problems. The Menninger Foundation, for instance, for years has sponsored a special seminar for the heads of large industries to learn more about the psychologic conflicts of employees.

Although someone may need psychiatric treatment, he *himself* has to want it in order that he be helped. He cannot be "forced" to go to a mental health clinic or to a psychiatrist in private practice, but attempts to motivate him to do so can be made. Sometimes the industrial psychiatrist, whether he is consultant or on the medical staff of a company, is able, by talking to the employee, to persuade him to undergo psychiatric treatment.

A psychiatrist's role in industry is broad and varied. He carries out his work as diagnostician and therapist not only with individuals but with groups. First and foremost he treats patients referred to him by the medical department of the company. But in the widest sense, his patients are not only the workers but the whole industrial crew and its component parts. And as a teacher, he shares his skill and knowledge with the industrial physicians in the medical department, as well as with nurses, personnel workers, supervisors of the various departments, and the executives themselves.

He should become a consultant to supervisors at all levels and to union leaders in problems involving human relations. He should point out to management and union leaders the vital part that good emotional health plays in productivity. He must stress again and again the fact that each worker is a human being subject to stresses that may produce such conflict within him that he is unable to work to his full potential, and that if he receives needed psychiatric help, not only will he be a happier person, but industry will benefit by his increased productivity.

The psychiatrist also has to point out the limitations of psychiatric help for those who are emotionally troubled or those who have the idea that it is "magic."

They must be helped to realize that for treatment to be effective they must work in a psychic sense in order to understand their conflicts.

A psychiatrist may also help in industry to work out those unconscious and emotional factors which slow down production and create social stresses, dissatisfaction and poor mental health. He can point out to management the importance of seeking and recognizing the sources of satisfaction or unhappiness in a worker. He can describe what workers want out of their job: security, job satisfaction, individual recognition, opportunity for advancement and a chance to belong to a group and work within a community.

Industry has gradually become aware of the fact that no matter how much the environment and the physical health of the worker are improved, it matters little if his mental attitude is not taken into consideration. The Hawthorne Experiment proved this.

This experiment was carried out at the Hawthorne works of the Western Electric Company, to investigate certain working conditions, such as the degrees of optimum illumination and the effect on employee productivity. But as the experiment progressed, it was discovered that, regardless of good or bad working conditions, productivity depended mostly on the esprit de corps of the working group.

This "esprit de corps" seems to depend, in turn, on the ability of the employees to get along together, to work in a common effort, a sense of belonging to a group and of contributing to a project, plus a sense of willingness to help each other out and to cooperate fully with supervision, when it was firm and understanding.

The Hawthorne experiment was a revelation to the investigators, in that they found themselves involved not in what they had started out to study — the effect of certain types of working conditions on productivity — but in studies of human nature, human relationships, behavior of personality types within the groups and the emotional makeup of the individual worker.

Ever since this experiment, conducted in the early 1930's, industry has become more aware of the importance of the mental health, mental attitude and emotional stability of the worker. His relations to his fellow workers, to his superiors, to his wife, to his children, and his aspirations and frustrations, all have a bearing on his productivity in the company. After all, he does spend one-third of his life at the place where he works, actually more than one-third if you rule out the sleeping hours.

During World War II, both psychiatrists and psychologists were used extensively in industry to assist in carrying out plans for the improvement of selection procedures, in developing training programs, and in furthering various activities aimed at maintaining employee morale at a high level. The use of industrial psychiatry has grown but even so, in many industries, as in most communities, standards of services provided for mental and emotional health are below those provided for physical health.

It has taken time for industrial leaders to realize that there are no problems in industry more urgent than those related to individual and group mental health. This is true whether considered from the standpoint of the difficulties in adjustment which people show on the job or from the long-range relationships existing among working teams and between the leaders in management and labor.

The psychiatrist cannot reach personally every member of management on every problem that may arise, but he may, through consultations, make contributions to insure that the mental health of the employees is taken into account. The first-line supervisor will have the closest contact with the greatest number of employees, and it is he who may require special individual counseling by the psychiatrist.

It is interesting to note that, as the executives themselves have received psychiatric treatment and benefitted from it, they want their employees to be relieved of the pain inherent in mental disorders. It has been said in jest, but with a ring of truth, that if someone is president of a company, for him to become aware of the mental health needs of his employees, he should go to a psychiatrist himself.

An industrial psychiatrist who sees an employee for treatment must first establish trust and confidence in what he does. He has to assure the employee that getting treatment will not jeopardize his status, that there is no stigma attached to it as far as the company is concerned.

The psychiatrist would do well to point out that a certain amount of personality strength is required in order for someone to ask for and accept treatment. The very severely emotionally disturbed person does not have this strength, is unable to accept psychiatric help until, at times, it is forced upon him in a psychiatric hospital.

The following are the steps a psychiatrist should take in developing training and counseling programs and in building up the mental health program in industry so that those with psychiatric disorders may be utilized properly:

1. The psychiatrist should consult with employment interviewers and help to train them in better methods of recognizing personality deviations, better interviewing techniques, basic principles of personality formation and motivations of behavior, with the aim of employing as many persons as possible, especially those who are "in remission" and who have been diagnosed as schizophrenic or manic depressive.
2. While not engaging in routine placement of applicants, in special instances the psychiatrist

should assist placement officers in reaching a decision about which they may have some doubts.

3. The psychiatrist should assist in solving all problems that arise in the employment of the mentally handicapped person as well as the physically handicapped, for the latter is apt to have mental conflicts. The psychiatrist must make sure the mentally handicapped person is hired for his assets and not fired for his disabilities if the latter can be corrected through pyschiatric treatment.
4. The psychiatrist can help the personnel and safety departments to understand and manage the problem of the accident-prone employee, for the large majority of accidents are caused by unconscious motivations and conflicts. Studies have shown that the employee who suffers accident after accident is also suffering intense emotional stress in his personal life, stress he cannot face openly without some psychiatric help.
5. The psychiatrist can assist psychologists and personnel workers in making sure that the use of psychological tests in placement and promotion will not produce any harmful effects which might negate the usefulness of the tests. Psychological tests should not be used unless they have been validated for specific jobs and unless clinically trained individuals are available to administer them.
6. An adequate follow-up on all employees who need psychiatric help should be instituted, so that whenever possible it is ascertained that employees who have had to leave their job temporarily are getting proper treatment, and that provisions are made for their return to their jobs when they are ready. The psychiatrist will have on hand those reports of workers whom he is personally helping. Those he has referred to other psychiatrists or family service agencies or mental health clinics in the community, he may have to keep track of by asking for progress reports.
7. The psychiatrist should act in the continuous training of the industrial physician in basic psychiatric principles and practices so the latter can help, when needed, with workers having emotional problems.
8. Treatment of many workers with emotional conflicts does not always require intensive psychiatric techniques but primarily, effective use of the simpler psychotherapeutic methods. The psychiatrist has the responsibility of assisting the industrial physician in the application of the proper interviewing and counseling techniques, as well as therapeutic techniques.
9. If clinical psychologists or other trained workers in the mental health field, such as social workers, are added to the medical or personnel staff, the psychiatrist should help them apply their specific skills to the needs of the workers.
10. The psychiatrist will also need to know the community resources which will help him, and to whom he can refer troubled workers. He should, if possible, interpret mental health to industry at large, to other physicians and to social agencies and institutions.

In a sense, the industrial psychiatrist is a pioneer in his field, a liaison officer between industry and the community, directly concerned with the emotional health of the workers in his company. Physicians and psychiatrists in the community usually know little of the industrial milieu in which their patients work. They could be far more effective therapeutically if they knew more about their patients' working conditions, and particularly if they knew that the company was interested in helping employees achieve better mental health.

The industrial psychiatrist can transmit, to other physicians, knowledge of the ways the emotionally disturbed employee might be helped. For instance, many physicians have advised a neurotic patient to take a month or two off from work and go on a vacation, or rest. Studies have shown that many a neurotic person is more likely to improve if he stays on the job as he gets psychiatric treatment. His neurosis may even become more intense if he lacks the stability and self-esteem building quality that a daily job brings.

Physicians are often called upon to make recommendations about the employment, reemployment, transfer, placement, or promotion of recovered mental patients, including those with minimal residual symptoms. They must also be prepared to consider the mental health aspects of employment for those who had not suffered psychiatric illness but who show excessive emotional reactions, or make unwarranted demands for special privileges, which sometimes occurs with those who return to work after an occupational illness or injury.

The employment of such people can be facilitated if everyone concerned is familiar with the kind of information the physician needs to make his recommendations to management. With such background information available to him, the physician can give his considered recommendations concerning the worker's employability and placement. But he should not include information of a confidential nature which is not needed for proper placement.

According to the *Guide for Evaluating Employability after Psychiatric Illness*, published by the American Medical Association, there are twelve factors which should be considered in appraising the employability of

a recovered psychiatric patient. These factors concern the individual's condition prior to, during, and after illness. The first four ordinarily occur prior to the illness, the next three during the course of the illness, and the last five after the illness, but there may be overlapping of any of them. The physician is advised to make his evaluation in terms of a *favorable, unfavorable, or borderline* condition. By using the best information available, and by weighing how the worker scores on all the factors, which add up to an "occupational mental health profile," the physician can determine the person's employability.

The twelve factors in the "profile" are:

1. Pre-illness personality
2. Somatic disorder
3. Off-the-job stress
4. On-the-job stress
5. Diagnosis
6. Treatment and rehabilitation
7. Course and duration
8. After-effects
9. Attitude and insight
10. Placement and transfer
11. Interpersonal relations
12. Follow-up

The *Guide* concludes: "The physician in charge of an occupational health program can exert a very wholesome influence in overcoming prejudice against the employment of individuals who have recovered from psychiatric illness. In most cases, performance, attendance record, and accident experience compare favorably with those of employees in general. If the individual can handle the job or can adjust to it in reasonable time, and if he has medical approval to work, he should be given the same consideration for employment as any other worker.

"In the final analysis, any worker must be evaluated as to his ability to perform a specific job. It is hoped that by evaluating the recovered psychiatric patient, physicians will be able to recommend his placement in a job in which he has the optimum chance of succeeding, and in general help create more understanding of the total problem of employment after psychiatric illness."

It is a challenge to industry to develop ways and means of employing the young men rejected from military service for psychiatric reasons, as they are often intelligent and may have much to offer. A good start has been made, but there is a long way to go, and it is hoped that before too long many persons heretofore felt unemployable will be able to work as, at the same time, they receive psychiatric treatment to help them overcome and control their psychiatric disorder.

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THE ROLE OF PSYCHOTHERAPY IN PSYCHOSOMATIC DISORDERS

Anita Stevens, M.D.[1]

ABSTRACT

Psychosomatic disorders call for all the skill and attention of the psychotherapist. The ills accompanying psyche upset are found literally from head to toe, from the inner lining of the intestinal tract to the outer layer of skin covering the whole person. Pains in obtaining history, in judging just when to establish close rapport, in deciding on whether to prepare the patient through supportive techniques and in avoiding too speedy symptom removal must be taken. The somatic disturbance itself may be the patient's way of discharging anxiety and hostility. Without great care by the psychoanalyst, anxiety may get out of hand and precipitate a psychosis. But careful psychotherapy will generally clear the disorder and restore the sufferer to health.

Even more important than in psychotherapy for the customary psychic disorders, is the close and constant attention of the therapist to the emotional needs of the patient in treating psychosomatic disorders.

Not only must the therapist take the most painstaking history in order to establish etiology, but he must also be ever alert to pick up new threads of information about the probable cause of the disorder being treated. These new bits of evidence come to light, just as they do in other psychotherapeutic treatment, as the warmth of relationship between therapist and patient grows.

It is sometimes important that the therapist establish as quickly as possible a close rapport with the patient, ideally in the first two or three sessions. Only when a deep confidence has been established can real progress be made.

At the same time it is important to go slowly in establishing close relationships in many cases. Since psychophysiologic or psychosomatic disorders are often rooted in the deep disturbances in the personality organization and engendered by defects in the earliest contacts of the infant with the mother, the personality structure of the patient consequently contains dependent, hostile, and masochistic elements. These elements tend to obstruct a good working relationship. Inasmuch as the egos in many patients are fragile, anxiety, mobilized by the transference and by interpretation in therapy, and more so in analysis, may be intolerable.

Insight therapy may, therefore, have to be delayed in favor of preparatory supportive techniques, during which the patient is gradually conditioned into transferring his dependency to the therapist.

The therapist must be on the lookout for hostile manifestations which the patient perhaps tries to conceal. But once a good working relationship is established, exploration of inner strivings, needs, and conflicts, followed by cautious interpretations, may be attempted *(1)*.

One of the most common signs of resistance on the part of the patient is his exaggeration of his physical symptoms. And as these symptoms increase in intensity, the patient may be tempted to break off therapy.

Treatment is generally a long-term proposition, since a deep personality problem associated with the symptoms resolves itself slowly.

But psychotherapy for psychosomatic disorder follows the design for the management of personality disorders. A constant danger during insight therapy is the unleashing of excessive quantities of anxiety, usually the result of too speedy symptom removal or too rapid dissipation of defenses. Often the somatic disturbance represents the most acceptable avenue

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available to the patient for the discharge of anxiety and hostility.

Because the ego has been unable to handle these emotions on the conscious level, the mechanism of repression is invoked.

Where coping devices are threatened without a coordinant strenghthening of the ego, where the person becomes prematurely aware of unacceptable conflicts and strivings, there is definite danger of precipitating a crisis. The patient may release such intense anxiety that he will employ contingencies to bind this emotion.

This means, Engel points out, any body experience which is perceived leaves behind memory traces which have the potential of becoming associated with other mental content and thereafter being used or reactivated as body language, a good definition of psychosomatic disorder *(2)*.

In Engel's words the term "perceive" is critical, because it differentiates silent physiological processes, such as increased gastric secretion as a response to an oral wish, from physiological processes which are perceived, consciously or unconsciously, such as nausea and vomiting as a reaction to contaminated food or even to the idea of contaminated food.

These latter processes may provide the perceptual data for subsequent conversion use.

It is this use of the part for the whole of the perception to represent a wish, a primary process operation, which constitutes the necessary first step of a conversion, Engel says.

I should like to talk about psychosomatic disorders in the human from head to toe, as it were. Let us start at the brain and then descend to the breathing apparatus, the neck region, the heart, the gastrointestinal tract with the stomach, smaller colon and lower bowel, the renals and adrenals, the locomotor functions and the covering for all these: the skin.

In my practice in New York I deal almost every day with patients whose positions as heads of large companies make them ripe for massive cerebral accidents. The ischemic brains of these patients are beset constantly by the intense demands upon them resulting from the highly competitive and stress-filled activities they carry on in their multimillion-dollar enterprises.

It takes constant, in fact, unceasing, watchfulness to contain and reduce the anxiety and tension ever present in these men. Naturally, I must watch for dizziness and other physical symptoms. But it is only with careful therapy, based on deep trust on the part of the patients, together with insight exploration, that I am able to maintain these patients on satisfactory levels of daily work and relaxation. Fortunately, I have been able to maintain several of these genuine tycoons at maximum efficiency without any incident of cerebral damage.

Asthma and hay fever, two of the most obvious of the psychosomatic disorders, are daily problems to anyone in active psychotherapy.

Asthma is particularly interesting to me, because my mother, who was born in Germany of American parents and who lived there until she was about 50, for many years baffled the best efforts of medical men in the Lower Rhine region where we resided.

Since, in her estimation, only American medicine was of any value, it was finally decided to bring in an expert from the United States to treat her.

Our American expert arrived in due time. For six weeks he treated my mother rather routinely, using the technique then popular of immunizing her with a vaccine extracted from her own sputum. All the time he was preparing and injecting the vaccine, of course, he was applying sound psychotherapeutic medicine. My mother's asthma cleared completely and never returned.

The neck region offers the interesting organ which psychiatrists study so carefully—the thyroid. With its control of metabolism and its responsibility for our rates of activity, it gives us a good control point often in managing disturbed patients.

I recall a youngish woman who had been in shock treatment for thirteen years prior to her coming to me. ECT had been given as a matter of course for her sleeplessness, her panicky activities, and her irrationality.

Several doctors had ruled out any possibility of thyroid malfunction in her case. But something about her appearance made me suspicious. I had her undergo a thorough work-up with the result that a competent surgeon did a thyroidectomy.

This helped the patient so much that she accepted me as her counsellor and this allowed us to enter into a rewarding program of psychotherapy. As a result, her underlying problems were cleared and the woman has done well for the past fifteen years.

Next we take up the heart and the coronary activities including circulatory ailments.

While some still cling to the notion that high cholesterol presence is all important as a warning signal about coronary accidents, some think cholesterol is an overrated factor. Whatever the facts about this, I

do have to watch for the tensions, anxieties, and depressions which are forerunners of psychosomatic heart disease and heart failures in these same patients for whom I must have a great care about brain damage.

Naturally, there is a correlation in the psychosomatic patterns of the brain-accident prone and the heart-accident prone.

I learned to be alert to this predisposition to the tensions that lead to heart accidents early in my practice.

As we know, EKG's don't reveal the psychic disturbances which underlie an oncoming seizure. The case to which I am referring is that of Mayo-trained cardiologist. He dieted himself extremely thin. He also maintained a low-cholesterol diet. But he had immeasurable tension and anxiety, which he went to great lengths to deny. This, despite the fact that he underwent frequent EKG's. He did predict for himself an early death.

But he would not accept psychotherapy. Instead he felt long vacations with lots of rest were the answer. So one summer he rushed off to the Riviera and promptly suffered a massive coronary occlusion, dying in four weeks at the age of 42. I keep the history of this young doctor in mind when I see the psychosomatic symptoms similar to his in my patients today.

I recall, too, another doctor, a radiologist, who, after a coronary, practically willed himself into two additional coronaries. He had a feeling of guilt because a younger brother had died of a heart seizure.

In connection with the coronaries we have the psychosomatic illnesses of the circulatory system.

These are characterized by depression which brings on extreme fatigue and low blood pressure. One of my patients, a young married woman, lay in bed practically all the time with feelings of exhaustion, listlessness, dizziness, headaches, indigestion, constipation, and so on, until we were able to introduce her to a regular regimen of psychotherapy and to get at the depression causing all these. She is now on the point of functioning as a helpful, cheery, and attractive housewife and mother.

The G.I. tract is a classic site of psychosomatic illness. The illnesses which afflict the stomach, small colon and large colon, as well as the upper and lower openings of the alimentary canal, are textbook items.

I should like to talk about three patients with psychosomatic G.I. disorders.

Former Gov. John E. Miles of New Mexico, who died recently, was a typical politician and statesman who suffered the colitis to which so many politicians are prone. Well-liked and wealthy through his own efforts, Governor Miles was frequently on the campaign trail. He held a number of offices, most of which were elective. These included his being Congressman for two terms after he had been governor twice and after he had been defeated for governor one or more times.

Because of the tensions attendant on campaigning, Governor Miles developed obstructive colitis for which he was hospitalized and underwent surgery a number of times. He was plagued by adhesions following surgery. The colitis would flare in times of stress, and the Governor had the sense to realize that further surgery was not the answer.

So he let me apply psychotherapy. Although our sessions were frequently interrupted by out-of-town speaking engagements, the therapy changed the whole course of the Governor's colitis and he lived to the ripe age of 87, keeping his faculties to the very end.

My favorite case of peptic ulcer was that of a handsome, talented, busy architect who built an empire in the Southwest.

The tensions of his life and work and the momism which was predominant in his psychic makeup led to an acute ulcer for which a stomach resection was performed.

When the symptoms continued, however, the architect came to me for psychotherapy. However he was too busy to have more than intermittent care.

The continuing tensions led to a coronary accident and this drove him into a deep depression with a suicidal crisis.

He came to me in New York from his Southwest enterprises. His condition was so acute that I prescribed ECT to prevent further injury to his coronaries. I also applied Thorazine following and during the ECT therapy. Then a relatively short regimen of psychotherapy brought on a remarkable recovery and the architect has had no recurrence of either illness in the past ten years.

A third type of psychosomatic disorder in the G.I. tract concerns a girl of 19.

I saw her during my residency at Bellevue. She had developed such G.I. symptoms as vomiting after meals, pains in her stomach and pains and tenderness in the abdominal areas. Frequent checks revealed no physical disease.

One day the young woman appeared in the surgical emergency room with symptoms of a boardlike abdomen and signs of peritonitis. These signs were a misleading blood count and evidence of infection. Unfortunately the blood picture could have resulted from anything, including influenza.

When the surgeons asked me for a psychiatric history, I gave it to them and advised them not to operate because the girl had had such episodes previously. But the eager beavers did an exploratory and found the patient negative.

Psychotherapy for the girl followed for several years and she has been entirely cleared of any symptoms for the past fifteen years.

A patient whose troubles revealed disturbance of the renals and adrenals in one was a man of about 50. He had recently reached the involutional phase of life with pronounced psychosomatic symptoms involving the whole system. His blood pressure would go extremely high, then reach exhausting lows. He had weight changes. Guilt manifestations over an extramarital affair brought on aneuresis.

Despite the previous extramarital activities, the man truly loved his wife and his family. By involving the wife and children as part of the psychotherapeutic course, by insight therapy, by close attention and encouragement and by being available via the telephone, we achieved a reversal of symptoms in a surprisingly short time.

The psychosomatic causes for muscular paralysis are familiar to us all. Rather than discuss phases of locomotor immobility, I should like to close on a note of accidental psychotherapy which cleared up a case of hysterical aphasia. While I was still practicing in Santa Fe, an old woman who had completely lost her power of speech and had gone to a number of doctors was brought to me.

At first we made no progress. But one day I was wearing a blue sapphire ring. The woman, who had been speechless for months, suddenly cried out, "Oh, this is a beautiful ring!"

We all know the skin offers an ideal surface for symptoms of emotional stress such as seborrheic eczema, acute herpes simplex, urticaria, and alopecia areata. These and other skin disease may be engendered or aggravated by emotionalism. Although the skin is diseased and although the psyche has played a role in causing the outbreaks, the individual himself does not produce the diseases. Instead, the skin eruptions are outlets for the underlying emotional disturbances.

Recent findings indicate that the therapist may have a useful adjunct in treating urticaria and other skin disorders. This is the Carbon Dioxide Rapid Coma Technique promulgated by Dr. Albert A. LaVerne, special consultant in clinical pharmacology, Department of Medicine, Hahnemann Medical College and Hospital, Philadelphia, who is on leave as senior psychiatrist at Bellevue Hospital, New York. Dr. LaVerne is editor of this Journal. He explains that Carbon Dioxide Therapy speeds the transference between patient and psychiatrist and greatly shortens the length of treatment needed to clear skin ailments and other psychosomatic disorders.

Of more interest to the analyst are those skin lesions which spring from neuroses, psychoses, and nervous habits. The subject with parasitophobia or one suffering from hypochondriasis will produce his own skin lesions. Nervous habits springing from these psychoses will include nail-biting, hair-pulling, cheek-biting, lip-licking, excessive hand-washing, and scratching.

It was because of my experiences in the practice of dermatology that I became interested in psychiatry and took up psychoanalysis. Needless to say, I have been rewarded hundreds of times over by the good results of careful psychotherapy in treating psychosomatic disorders of the skin.

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EMOTIONAL CONFLICTS AND PHYSICAL ILLNESS:
THE PSYCHIATRIST'S ROLE

After a thorough physical examination and medical history fail to reveal the cause of the patient's illness or pain, the physician often thinks about possible psychosomatic origins of the complaint and turns to the psychiatrist for consultation and assistance.

The psychiatrist in turn must be alert enough to spot a physical basis for an illness that may have been diagnosed as rooted in an emotional or psychic disorder and refer the patient to a specialist.

But once he knows he is dealing with an illness activated by an emotional conflict or psychic disturbance, the psychiatrist must rely on his own curative resources. These include the various forms of psychotherapy--investigative and supportive, etc.--psychoanalysis, pharmacotherapy--the use of medications--and electro-convulsive therapy among others.

What I have to say tonight will be familiar to everyone here. But I thought a review of our findings in psychophysical medicine might be in order. To you to whom this might seem old hat I offer my apologies.

At Gracie Square Hospital
June 5, 1974

Internists and surgeons use a variety of procedures and mechanical and electronic aids to investigate the patient's symptoms. In most cases they find a specific physical basis for the complaint. Often, however, a blocked libidinal drive or a repression stemming from an experience of infancy may be responsible. In these latter cases the psychiatrist is sometimes asked to assist.

The threshold and duration of pain cannot be accurately measured. The schizophrenic patient sometimes builds up a denial of pain that can be almost baffling.

When I was interning at Bellevue years ago--and some of you were my professors or colleagues at the time--a patient who had fractured her leg in a fall was waiting in emergency for a surgeon to appear to apply protection and support for the fracture. She decided her leg didn't hurt, got up abruptly and created a compound fracture. I was called in a hurry and told her what she had done but she still denied to me that she felt any pain.

At the other extreme in schizophrenia, is the patient who imagines his pain. I also saw during my residency at Bellevue a girl of 19 who had developed pains in her stomach and tenderness in the abdomen as well as vomiting after meals. Tests indicated there was no physical basis for her symptoms but rather a psychic reason for them.

The young woman appeared in surgical emergency one day with a board-like abdomen and signs of peritonitis. I urged the surgeons not to operate when they asked me for her psychiatric history, because the girl had had such episodes previously. But a laparotomy was done. The results were negative.

After long psychotherapy the girl was entirely cleared of symptoms.

On the other hand the schizophrenic rarely seems to develop cancer. This was pointed out only last month at a meeting sponsored by the Johns Hopkins Medical School and the Maryland Division of the American Cancer Society.

A psychiatrist and a surgeon, speaking at the Baltimore conference, which was devoted to the spontaneous remissions of cancer, suggested there was a definite link between personality and cancer.

The psychiatrist, Dr. Rene Mastrovito, of the Memorial Sloan-Kettering Cancer Center, said that women who contract cancer of the reproductive tract tended to have high emotional self-control, idealism and a sense of responsibility.

His findings were based on a study of about 30 carcinomic wives and of their husbands designed to help couples cope with the stresses brought on by the need for cancer surgery.

Extensive psychological and psychiatric research suggested links between personality and cancer and seemed to agree with his preliminary findings, Dr. Mastrovito said.

He added that testing revealed that cancer patients commonly tended to be inhibited in their feelings of anger and hostility and such patients tried to repress their anger rather than curse, swear, kick and throw things.

Since cancer and mental illness, occurring widely, are rarely found in the same patient, more joint study by psychiatrists and cancer specialists would be indicated, Dr. Mastrovito observed.

In connection with this, some research I did recently on hypnotherapy turned up a paper by Dr. William Miller, a midwest psychiatrist, who had told a session of the American Psychiatric Association some years back of his experience in using hypnosis for patients with breast cancer. Dr. Miller reported encouraging success in reducing, and in a few cases helping to remit, breast malignancies through hypnosis. Dr. Miller also urged further study by psychiatrists and cancer specialists of this avenue of treatment

Several speakers at the Baltimore conference attributed psychological factors to the myriad possible contributing circumstances that might help or harm the cancer patient.

Dr. Alfred S. Ketcham, chief of the surgery branch of the National Cancer Institute, suggested that profound psychologic effects might have physiologic consequences affecting the cancer process. He pointed out the brain had great effects on the hormonal balance of the whole body.

The complex and variable factors, including surgery itself, affecting a cancer patient, could have deep psychological effects with possible accompanying changes in the hormonal balance, Dr. Ketcham said.

He recalled the neoclassic case of the patient suffering apparently incurable cancer who developed a severe psychosis with accompanying regression of the cancer. Although the psychosis cleared in about six months, the patient enjoyed seven years of apparently complete health before cancer reappeared. This seems slightly contradictory to what I said earlier about schizophrenia and cancer but the psychosis was transient and episodic in this case.

As I say in my book, Your Mind Can Cure, emotions are considered by many as the cause of most physical distress.

There is no organ of the body, no system of the body, that may not be affected by emotional conflict. The ills accompanying mental anguish are found literally from head to toe and from the inner lining of the intestinal tract to the outer layer of skin covering the body.

Over the years in which I formerly practiced medicine and since then as a psychiatrist I have seen patients with almost every conceivable illness. A vast number of these illnesses could be traced to emotional conflicts, many of which had been denied since childhood and were activated by current problems. It was my growing awareness as a physician that the underlying causes of specialized complaints were emotional which led me to become a psychiatrist. I have discovered that all physical illnesses are closely connected to personal problems and internal stress.

It is to Sigmund Freud, of course, that psychiatrists and other doctors owe the knowledge that the psychic mechanisms involved in falling psychically ill can also cause physical illness.

Freud demonstrated how a paralyzed arm could be the result of "paralyzed" emotions. How a headache could reflect the wish not to think about something dangerous to the self-esteem. How blindness could represent the wish not to see something regarded as obscene and evil.

Freud also discovered the way of reaching hidden emotions so physical illness could be eased. Today most of the medical profession accepts the idea that physical illness is the way our body may respond to an emotion or thought we believe menaces our psychic survival.

Psychiatrists call the illness, whether it be earache, stomachache, headache, or ulcer, a "symptom." The symptom is the surface eruption of the buried feelings that are causing distress and seeking some outlet. The symptom is one way of discharging anxiety aroused by hidden feelings tied to some wish that is forbidden fulfillment by our conscience.

A symptom may reflect not only reality but also fantasy. If you imagine you are being poisoned, this may cause the same reaction in your body as though you were poisoned. A man bitten by a snake he believes to be poisonous dies, not from the snake venom because the snake was not poisonous, but perhaps from a coronary brought on by fear.

Dr. Walter B. Cannon, the esteemed nonpsychoanalytic researcher, showed that the direct expression of psychological states could produce physical symptoms. He proved that emotions--particularly rage--caused profound changes in blood chemistry. These changes were principally due to the production of sugar by the activity of the adrenal glands.

Disturbances also occurred in the respiratory and circulatory systems and gastrointestinal tract. Cannon measured changing units of hydrochloric acid secreted by the stomach, variations in blood pressure and disturbance in heart rhythm.

He proved that when a flood of anxiety pours into the brain's higher cortical centers anxiety may paralyze these centers. Our autonomic nervous system goes into action as a kind of substitute director.

Dr. Flanders Dunbar in Emotions and Bodily Changes pointed out two misunderstandings about the causes of physical illness. One was confusing the physiological mechanisms through which the psyche operates with the fundamental cause of the illness. The second was assuming that a psychological cause must be a conscious conflict.

Actually the psychic causes of physical illness are usually unconscious. If they were conscious, there would be no need to fall ill, for we could consciously handle the conflicts. Reconstruction of the psychic structures of organic disturbances, whether they are organic diseases or organic neuroses, shows the organic symptoms, as well as their meaning and tendencies, have the same origin as the psychic symptoms of a neurosis.

Cannon in his Bodily Changes in Pain, Hunger, Fear, and Rage, in 1929, demonstrated that the thalamus was concerned with the emotional aspects of sensation.

Cannon found the viscera were controlled only at the thalamic level, whereas skeletal muscles were governed at both cortical and thalamic levels. The cortex, he found, cannot cause, nor can it prevent, the intense, violent emotions that increase the blood sugar in the body, or step up the processes of the heart, or interfere with our digestion. When we feel a deep emotion, we can repress it, but only in its outward expression. It will still have an effect on our bodily processes.

Cannon believed that emotional expression resulted from the action of subcortical centers (the unconscious) and that thalamic processes were a source of emotional experience.

So it is that our conscious feeling about an emotion results in the interaction between the processes of our thalamus, the seat of our primitive feelings, and our cortex, the thinking part of our mind. So it was only recently noted, except briefly, in medical literature, that it is our limbic system which makes this interchange possible. The limbic system is a kind of message center that facilitates the exchange between the thalamus and the cerebral cortex.

For instance, a sensation of wishing to fight someone may occur in the thalamus and then be relayed through the limbic system to the cerebral cortex which, in light of our past experiences, decides what to do--whether to accept, modify, or reject the wish.

Dr. Hans Selye, author of The Stress of Life, another non-psychoanalytic scientist, supported Cannon in the belief that changes caused by emotion can affect every cell in the body. In his research on cortisone, Dr. Selye found the two-headed result of the increased output of hormones, including androgen, had to be watched carefully. Cortisone or ACTH was for a while used to calm neurotic patients but it was found to have the opposite effect and created a psychotic break in some. The body is not the sum of its parts. For psychic processes are involved in its movements, giving a certain quality to the way we act and think. These mental processes are governed by what Freud called "the principle of constancy." The psychic processes strive to maintain an equilibrium in the mind so that it is free for conscious thought.

The "principle of constancy" governs the operation of our psyche. This is very important to remember in the discussion of the relation between bodily ills and emotional conflicts.

To understand how an emotion may be transformed into a physical illness requires explanation of the mental process Freud called conversion.

As the first step in the mental process of conversion, one of our psychic processes called repression goes into operation. We "repress" or relegate to the unconscious part of the mind something we believe painful or dangerous to self-esteem. It may be the wish to strike someone who has insulted us, the wish to have sex with someone who belongs to another, the wish to masturbate, the wish to have physical relations with a member of the same sex.

The aim of the unconscious psychic process of repression is to weaken psychic pain, to take away from the thought some of its emotional force. The process of repression does so by diverting the psychic energy attached to the wish into some channel of the body where it will not be felt so intensely. The organ affected is somehow related to the very thought.

Thoughts never vanish. No thought is ever lost to the unconscious, which stores it forever. Sir Charles Scott Sherrington, Nobel Prize winner in physiology, showed that in the case of two reflexes seeking a common pathway of expression, with only one able to get it, the other just bided its turn and occurred as an "after-discharge." The energy of the inhibited reflex did not disappear but persisted in undiminished strength, waiting to take effect later. In other words, a drive, temporarily inhibited, has by no means renounced its goal or satisfaction but simply postponed it to a more favorable time. Or, as Freud discovered, if denied an outlet, the drive had to be satisfied with partial expression in some organ of the body.

Memories and emotions, according to Dr. Calvent Stein, in Nothing to Sneeze At, operate through the sympathetic or autonomic nerves. The autonomic nervous system is described by Stein as an accessory nervous system that is like the automatic signalling devices on our railways.

He calls it a gigantic secret service which has agents (nerves, hormones, ganglia or nerve switchboards and glands) and operates silently, swiftly, and efficiently all over the body.

"It is largely on its own," Dr. Stein writes, "but it is in cahoots with our emotions and reports to headquarters (the conscious mind) in its own good time. It also uses a secret code, which our conscious mind may be unable to decipher. The code is represented by our 'neuroses,' that is by our psychosomatic and psychovisceral or 'functional' disorders--complaints for which no apparent organic or structural causes can be found. These coded messages are our traffic warning signals. Like our great naval operations, when months of planning and preparation are unknown to us until after the assault has begun, our neuroses are often well established before we are aware of them."

He goes on to state, "Our neuroses are the unconscious penalties which we pay for our emotional'crimes,' most of them imagined."

Our life is governed by our wishes, both conscious and unconscious. It is the wish that comes first; then the mind decides what to do about it. We cannot move without the wish propelling our body into action. The wish upsets the"constancy" of the mind. It arouses tension in the psyche. Until the tension is eased, the psyche will be overwhelmed by stimuli from within and without and cannot function. Or it will function poorly, which is what happens in psychosis.

Our unconscious system uses an organ of the body as an outlet for a partial, symbolic gratification of a wish. In a sense, we kill or hurt ourselves a little to prevent ourselves from actually killing or hurting someone else.

A woman came to me with an outbreak of skin rash which she could not seem to get rid of. During her analysis she revealed a strong unconscious desire to masturbate--the result of feeling unloved by any man--which she had repressed for years. Instead of touching herself in forbidden places, she scratched the irritating rash, in displacement of the area she really wanted to "touch."

Why does one person suffer from poor vision? Another fall ill of a heart attack? A third get ulcers? A fourth, cancer? A fifth, diabetes?

Psychoanalysts believe the answer lies in the erotic and aggressive experiences of the person affected and his reaction to them. It is possible that the organ or the organ system that becomes diseased is one that, in fantasy, has become what Freud called erotized, the part on which sexual tension has been displaced. That part of the body used erotically in fantasy for a forbidden sexual wish is the part eventually destroyed or hurt. It may be, too, that the part of the body affected was the actual target of an erotic sensation in childhood.

You among my colleagues who treat patients for lingering psychosomatic symptoms know that it takes constant, unceasing watchfulness to contain and reduce the anxiety and tension responsible for illness brought on by emotional distress.

With careful therapy and insight exploration we are usually able to restore and maintain our patients at satisfactory levels of work and relaxation.

As we all know, the whole human organism, from head to toe, is subject to psychosomatic disarrangement.

From the scalp through the brain, the breathing apparatus, the neck region, the chest, the heart, the gastro-intestinal tract, the renals and adrenals, the pelvic region, the locomotor system and the covering for the body, the skin, we can expect to find some outbreak of physical distress brought on by emotional dysfunction.

In dealing with business men/patients who suffer ischemia of the brain, a psychiatrist finds it particularly important to develop a deep trust on the part of the patient to reduce tension.

Recent studies on the prevention of clotting of platelets in the small vessels of the brain through the use, night and morning, of ten grains of aspirin have apparently given us a valuable tool in dealing with brain ischemia.

I am grateful to Dr. John S. LaDue, who is here tonight, for his advocacy of this regimen.

Sometimes called the gland of emotion, the thyroid often exhibits symptoms of malfunction soon after a psychic trauma. Patients with thyroid conditions who go into psychotherapy and receive proper medication by their physicians find their thyroid condition improves as they feel more at ease within themselves.

Anyone doing psychotherapy is usually treating one or several cases of asthma and hay fever, among the more obvious of the psychosomatic disorders.

The shoulders and arms are often the site of arthritis resulting from changes in muscle tonus brought about by psychic distress. The changes are connected to an inhibition of a desire to carry out activity involving the muscles.

Clinicly increased muscle tension brought about by sustained agressive impulses appears to be a pathogenic factor in rheumatoid arthritis, according to Dr. Franz Alexander.

When an arthritic can express his rage, frequently his muscles will relax and the arthritic condition disappear. In arthritis a calcification of the joints takes place as though the person were continually building up his resistance to an awful urge. We often find during analysis that muscular tensions vanish as psychic conflicts are brought out into the open.

When we psychiatrists are faced with complaints of coronary and circulatory ailments, we are actively aware that there are patterns of self-destruction among the heart-accident prone just as there are among the brain-accident prone.

Recently a physician referred to me a man of 55 with a diagnosis of psychosomatic heart illness. He did display symptoms of precordial pain and had complained about them for years to an unsympathetic younger boss who ordered him to run up and down the stairs to get rid of the pain. The man was, incidentally, a schizophrenic. After a long workup and despite the patient's denial of symptoms, the medical internist I consulted found the man was suffering from an acute peptic ulcer.

A memorable case of peptic ulcer involved a busy architect whose tensions and momism made necessary a stomach resection for an acute ulcer--with no relief of symptoms. Continuing tension led to a coronary accident and a resulting deep depression and a suicidal crisis.

To prevent further injuries to his coronaries, I prescribed electro-convulsive therapy and Thorazine during and following the ECT. It took a relatively short course of psychotherapy to bring about recovery. The architect has had no recurrence of either illness in the past 12 years.

A case of psychosomatic illness of both the renals and adrenals was that of a man of 50 who had reached the involutional phase with pronounced psychosomatic symptoms involving his whole system. His blood pressure would shoot high then drop to exhausting lows. He had weight changes. Guilt manifestations over an extramarital affair brought on aneuresis. The man responded to psychotherapy and medication and to family therapy. In a relatively short time he had a reversal of symptoms.

All these patients were referred to me by their physicians who had spotted the psychosomatic aspects of their illness.

Muscular paralysis, brought on by hysteria and other psychic disorders, is a familiar problem for most physicians. Hidden fears and angers, particularly in a passive-agressive personality, frequently bring on cramps in the arms, back and legs that respond only to prolonged psychotherapy.

Impotence, premature ejaculation and so-called frigidity are among the best-known psychosomatic symptoms psychiatrists encounter. Often, of course, sexual inadequacy is the result of experiences in infancy.

Sexual inhibition may express itself as shyness towards the opposite sex, a lack of interest in or disgust about the sexual act. Such emotions serve as a defense against deeper sexual conflicts which usually remain repressed as long as sexual intercourse is avoided, or, in extreme cases, as long as they are not brought to awareness by psychoanalytic treatment.

Impotence is a symptom which serves as a protection against impulses and conflicts felt to be dangerous. It may help in repressing sadistic fantasies, such as the one that the penis is a powerful, destructive organ that could harm or destroy a woman. This fantasy is a denial and projection of what Freud called castration anxiety, which is said to be the basic cause of all sexual inhibitions in males.

According to psychoanalysts premature ejaculation represents a fixation of "urethral eroticism." This fixation involves an unconscious identification in the psyche of semen with urine. This brings about an impulse to eliminate as soon as pressure is felt.

Vaginal disturbances as a defense against sexual intercourse offer a direct example of a defense against sexual desire. Here a body organ is used to deny the conflict between the feeling of sensuality and the prohibition against it.

We all know that the sexual glands have a strong influence on temperament and behavior. Freud theorized that disturbed chemistry of the sexually unsatisfied person produced anxiety and led to other symptoms. This theory has been proved by biological studies. Psychoanalysis shows that the maturation of the sexual functions and the integration of the personality are closely intertwined.

The skin is one of the body's most responsive organs when it comes to feelings of love or hate. Any disruption or eruption of the skin indicates strong feelings within a person. Many skin diseases are so resistant to any form of treatment other than psychotherapy that dermatologists are becoming more and more aware that psychic conflicts are involved when acne, eczema, psoriasis or allergic symptoms persist.

Our feelings are revealed through the skin. We blush, we pale, we get goose pimples, we flush and we perspire. Outbreaks of the skin combine a variety of hidden emotions, including rejection, guilt, masochism, a deep desire to receive physical expression of love from others, and exhibitionism.

Sexual impulses, when unconsciously directed to parts of the body, result in a feeling of guilt. One patient described the feeling he got from scratching as "a vicious kind of pleasure."

Many of you know I used to practice medicine in Sante Fe, New Mexico, and helped to set up a number of clinics for the needy. As my list of patients grew, so did the telephone calls in the middle of the night from people who complained about conditions that had persisted for days and weeks.

"But why did you call me at this hour?" I usually asked.

"Because it always seems much worse at night and I just had to call you, Doctor," they would say.

It was then that I became acutely aware of the psychosomatic basis for so much illness and decided to come to New York and enroll at Bellevue for the long grind of becoming a psychiatrist.

In my studies and subsequent practice I have come to conclude you can think yourself sick, and conversely you can help think yourself well. The more knowledge you possess about yourself, the more positive and helpful your attitudes will be towards yourself and life in general. For it is the unreal fears and rages and guilt that keep you in a negative frame of mind. If you cannot face those debilitating, strength-sapping emotions, you will keep on unconsciously punishing yourself for having them.

As you come to understand that fears, rages and guilts are natural feelings belonging to all men, and that if you have exaggerated them you have done so because of the hurt in your life, you will no longer suffer anxiety. You are a human being and entitled to all the emotions everybody possesses in order to express how he feels.

As you face deeper feelings, you will find your entire attitude toward life changes. Life becomes a challenge, a pleasure, a journey to be enjoyed, rather than a suffering to be borne.

This comes through a positive mental attitude, one in which you understand and accept yourself. It is an understanding and acceptance that wise men through the ages have advised for each of us if we wish to feel fulfilled, to enjoy our capacities to their fullest potential.

I base my treatment not only on Freudian principles but on all psychoanalytic schools that play their part in understanding human nature. I am what is called eclectic, a psychoanalyst who uses--if practicable--the methods of all schools. I have made it a particular specialty to employ short-term therapy to relieve the patient from his immediate suffering.

I believe it is important to reduce immediate anxiety so a patient's mental outlook will be more positive and make him more amenable to searching for an appraisal and analysis of the cause of his illness and its consequences. Then he will be able to apply his rational mind to the cure of his psychic and physical ailments.

I know, from the many patients I have seen over the years, the destructive effect on the mind and on the body of hidden anger, hidden fear, hidden jealousy, hidden grief. As the anger, the fear, the jealousy, the grief are able to register in the patient's consciousness, it is as though a veritable flood of feeling bursts forth, followed by a deep sense of calm and confidence. As the patient realizes how needlessly guilty he has felt, usually over fantasies, an ease and accommodation in his life-style result.

It is these feelings of guilt, fear, and hidden rage that contribute to and cause many of our physical complaints. And it is a proven fact that physical illnesses clear up in patients whose psyches have become freed of long-buried conflicts.

There is nothing wiser than the advice given by the ancient Greek oracle at Delphi: "Know thyself."

Thank you for your patience and courtesy.

end

FRONTIERS OF MEDICINE

IMMORTALITY--
ON 2 A DAY

By ANITA STEVENS, M. D.
and JOHN SANFORD HARPER

[illegible] aspirins a day keep the Reaper away.

[illegible] say doctors at the New York Hospital-Cornell Medical [illegible], one of the most prestigious medical centers in the

[illegible] physicians and other gerontologists attending arthritics [illegible] medical centers throughout the world noticed that pain-[illegible]ridden sufferers of the joint diseases had been living to 95, 100 and 105 years, far longer than the ordinary life span, particularly of the ill.

The doctors noticed, too, that the arthritics retained mental acuity right to the last.

The one common denominator in this phenomenon was that the arthritic patients received aspirin as a matter of course in their treatment.

This led, after extensive study and research, to the conclusion that everyday aspirins prevented clotting of the small blood vessels in the brain and thus warded off the thousand "small strokes" which insidiously but inevitably destroy so many people from early adulthood on.

(more)

At recent symposiums it has been concluded that two regular aspirin tablets a day, by their action on the blood platelets, significantly decreases clot formation.

Platelets are circular or oval disks floating by the millions upon millions throughout the blood stream. Their main purpose is to coagulate blood and cause a clot to contract when a blood vessel has been injured.

Discovered 2 Decades Ago

They can do this because they have a sticky substance on their surfaces which enables them to build up to the point where they can create a thrombus which plugs the blood vessel.

It is these plugs or clots in the same arterides of the brain which cut off circulation and bring on "small strokes." They shorten life and impair brain function.

Harvey J. Weiss, M. D., at Roosevelt Hospital in New York, has conducted a number of experiments to test the aspirin theory.

Dr. Weiss knew that French investigators in the 1950's had discovered that aspirin prolonged bleeding time but their findings were not acted upon until the 1960's when A. J. Quick, M. D., began to write about aspirin and bleeding

Dr. Weiss and his colleagues began experimenting with volunteers who took aspirin tablets and placebos to test whether aspirin did indeed discourage clotting by placebos.

These tests, and similar tests on animal and human subjects, proved that acetylsalicylic acid, of which aspirin is composed, interfered with the way platelets agglutinated.

(more)

Blocks Reaction Waves

Platelets ordinarily will not adhere to the inner lining of the blood vessels unless that lining has been broken but, once it has been broken, collagen, an albuminoid protein, attracts the platelets.

As soon as the platelets adhere to collagen, they release a substance which in turn brings on changes in the platelets that drive them to congregate in one spot. Collagen also causes other substances to break loose and circulate in a process that is called the platelet "release reaction."

By inhibiting these two waves of platelet reaction, aspirin keeps the blood flowing smoothly through the damaged arteries.

Most researchers point out that aspirin should not be used when bleeding disorders are present.

Aspirin has also been helpful in preventing clots around prosthetic heart valve implants, according to a University of Washington School study, and in hip joint replacements.

The latter was reported after experiments at the Massachusetts General, New England Baptist and Beth Israel Hospitals and the Harvard Medical School in the Boston area.

Aspirin is sometimes used in combination with dypirdamole and other drugs to prevent platelet agglutination, according to Marjorie B. Zucker, Ph.D., who reported on an extensive study on humans by blood research laboratories of the American National Red Cross.

It is suggested that an antacid be taken along with the aspirin each day to prevent damage to the stomach lining and its accompanying distress.

(more)

A simple remedy, long in use, has become a bright new discovery on the frontiers of medicine.

NEXT:

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ANITA STEVENS, M. D.
DIRECTOR

TELEPHONE
212-371-3557

Martin J. Cohen, Esq.
American Home Products Corporation
685 Third Avenue
New York, N. Y. 10017

Dear Mr. Cohen:

In accordance with your request that I review the use of daytime calmatives, I have in fact studied and analyzed their use over the past decade or so. I have also consulted a number of my medical associates about their experiences in this area.

Anxiety and tension--stress--bring on more physical and emotional disorders than any other factors in the United States today.

As a psychiatrist I prescribe regularly tranquilizing and antidepressant medications of varying potencies to counteract the anxieties and tensions which my patients manifest.

Bases for psychological disturbances of this sort are friction between spouses and between parents and their offspring, feelings of inadequacy about work at home and at employment, illnesses or deaths of loved ones and senses of guilt over real or illusionary minor misdeeds.

Patients who visit the psychiatrist are as a rule more emotionally troubled than the persons who try to cope with occasional stress situations. But the homemaker or employed worker who uses, as the need arises, a mild daytime calmative purchased over the counter achieves a similar restorative result as the patient for whom the physician prescribes a prescription-only psychothropic medication.

(more)

Both are soon restored to a level of tranquility and reasonableness which enables them to cope with their trying situations. Both are more sociable. Their blood vessel constrictions, intestinal turmoil, headaches and general tenseness subside.

Experience and research of my colleagues in several disciplines of medicine and me have revealed no serious side effects from use of over-the-counter daytime calmatives.

Indeed the ingredients and combinations of ingredients in these products would lead one to expect only short-acting--but welcome--relief from transient stress.

It seems to me the public has every right to ready access to non-prescription, non-addictive, calmatives, particularly in view of the fact they are far more desirable than habituating alcohol, nicotine and marijuana in relieving anxiety and tension.

In my opinion, the daytime calmative products under consideration serve a need in today's troubled society.

Very truly yours,

Anita Stevens, M. D.

End of Anita Stevens Collection